HIV EMERGENCY RELIEF GRANT PROGRAM FOR ELIGIBLE METROPOLITAN AREAS

THE RYAN WHITE COMPREHENSIVE AIDS RESOURCES EMERGENCY (CARE) ACT

TITLE I

FY 2004 GRANT APPLICATION GUIDANCE

July 25, 2003

CATALOG OF FEDERAL DOMESTIC ASSISTANCE (CFDA) 93.914

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SECTION I:

INTRODUCTION

Section I: Introduction

I. A. BACKGROUND AND OVERVIEW

This document is provided to assist communities in preparing their Fiscal Year (FY) 2004 single-grant application for funds under Title I, the "HIV Emergency Relief Grant Program" of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. This Guidance contains application instructions for both formula and supplemental funds, including specific references to the CARE Act as it applies to each section of the Guidance. In addition to the application instructions, the Guidance communicates information on current and new program initiatives. It provides background on reporting requirements, progress reports, and other forms of documentation that will be required from grantees, once awards have been made.

Program Authority

The authority for this grant program is the Public Health Service Act Public Law 101-381, as amended by Public Laws 104-146 and 106-345, the Ryan White CARE Act Amendments of 1996 and 2000. The CARE Act amends Title XXVI of the Public Health Service Act (42 U.S.C. 300ff-11 *et seq*.). The U.S. Department of Health and Human Services (DHHS) administers the Title I program through HRSA, HIV/AIDS Bureau (HAB), Division of Service Systems (DSS).

Who is Eligible To Apply

Eligible Metropolitan Areas (EMAs) are those metropolitan areas that were eligible under Title I for FY 2003. These EMAs include communities with a population of 500,000 or more that have reported to the Centers for Disease Control and Prevention (CDC) a total of more than 2,000 cases of AIDS in the most recent five calendar years [See: CARE Act Section 2601 (a), (c) and (d)]. The Chief-Elected Official (CEO) of the EMA is responsible for submission of the application.

When Funds Will be Available

Shortly after the President signs the Congressional appropriation for the CARE Act, each EMA will be notified in writing of the amount of Federal funds available under Title I for FY 2004. Notification will be sent to the CEO as indicated in the letter accompanying the Standard Form (SF) 424 and to the delegated administrative agency dispersing Title I CARE Act funds. To ensure timely notification of the release of the FY 2004 Application Guidance and other important documents relating to the Title I grant, EMAs must forward personnel, address, e-mail or telephone changes to the Division of Grants Management Operations, HRSA, Parklawn Building, 5600 Fishers Lane, Room 11A-15, Rockville, MD 20857.

Guidance Changes for FY`04

The Application Guidance has been streamlined based on information provided by grantees to DSS. DSS hopes the following changes/adjustments will assist EMAs and Planning Councils in understanding and completing the application.

- Consolidation of the Women, Infants, Children and Youth (WICY) information;
- Landscape format for all Tables; and
- Placement of the FY`03 Progress Report in the Formula Section.

HAB recognizes that Title I EMAs have in the past developed continuums of care that attempted to meet needs of all PLWH within the EMA. CDC's Initiative "Advancing HIV Prevention: New Strategies for a Changing Epidemic" may identify significant new numbers of PLWH who will be seeking services. This will require a careful reassessment of how the EMA will assure access to primary care and medications, support the State ADAP program, and ensure provision of critical support services necessary to maintain individuals in the system of care. This guidance also focuses on conducting a needs assessment process consistent with CDC/HRSA's "Integrated Guidelines for Developing Epidemiologic Profiles." In addition, the Supplemental Section of the Guidance places greater weight on performance, relative to the grantees' ability to closely monitor subgrantees.

I.B. REVIEW AND SCORING OF THE APPLICATION

The FY 2004 Guidance requires applicants to demonstrate that the EMA conducts a planning process guided by HIV/AIDS incidence and prevalence data and by a formal assessment of service needs in communities impacted by HIV/AIDS. Applicants must show that a continuum of care exists in the EMA consistent with the level of need identified. This includes comprehensive primary care services, preventive and support services. The applicant also must maintain linkages to other funding sources that support people living with HIV. In addition, applicants must clearly describe how they ensure the quality of services and evaluate the outcome of service delivery. Finally, the applicant MUST describe how data were used to plan for changes in the epidemic. In addition to these requirements, the FY 2004 Guidance response should reflect a careful reassessment of service priorities and resource allocations that reflects consideration of CDC's New Strategy for A Changing Epidemic Initiative. Specific instructions for responding to these and other components of the application are addressed in Sections III and IV of the Guidance.

Under Section III, instructions are provided for completing the Formula Funding Request portion of the application. EMAs are entitled to receive a formula grant based upon an adequate response to the documentation required in this section. Please refer to Appendix 5 for detailed instructions on completing the SF 424A and the Budget Narrative Justification.

Under Section IV, information is requested for the Supplemental Funding Request. The FY 2004 Supplemental Application will be reviewed and scored by an objective review panel through HRSA's Division of Independent Review. The amount of Title I Supplemental funds awarded to an EMA will depend on the amount of the FY 2004 appropriation, the relative need

in the EMA as reflected in the Congressionally-mandated formula used to determine the Title I formula award, the amount of supplemental funds available after requirements in the formula award have been met, and the applicant's numerical score on the supplemental application as determined by the review process.

I.C. PROGRAM SCOPE AND FY 2004 PROGRAM FOCUS

LEGISLATIVE SUMMARY

Section 2604(b)(1)(A) and (B) *defines eligible services as "… outpatient and ambulatory health and support services, including case management treatment, substance abuse treatment and mental health treatment, and comprehensive treatment services, which shall include treatment education and prophylactic treatment for opportunistic infections, for individuals and families with HIV disease; and inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities."*

Title I funds provide direct financial assistance to EMAs that have been the most severely affected by the HIV epidemic. Formula and supplemental funding components of the grant assist EMAs in developing or enhancing access to a comprehensive continuum of high quality, community-based care for low-income individuals and families with HIV disease. A comprehensive continuum of care includes primary medical care for the treatment of HIV infection that is consistent with Public Health Service (PHS) Treatment Guidelines. Current treatment guidelines are available at www.AIDSinfo.nih.gov. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections as well as combination antiretroviral therapies. Comprehensive HIV/AIDS care also must include access to substance abuse treatment, mental health treatment, oral health, and home health or hospice services. In addition, this continuum of care should include supportive services that enable individuals to access and remain in primary medical care as well as other health or supportive services that promote health and enhance quality of life.

In preparing the FY 2004 grant applications, EMAs should consider the following four guiding principles identified by HRSA/HAB as having significant implications for HIV/AIDS care services and treatment:

- Revise care systems to meet emerging needs;
- Ensure access to quality HIV/AIDS care;
- Coordinate CARE Act services with other health-care delivery systems; and
- Evaluate the impact of CARE Act funds and make needed improvements.

Grantees and Planning Councils should refer to these four principles as they develop their HIV/AIDS care implementation plans for FY 2004 and future years. In addition to HAB's guiding principles, the Ryan White CARE Act Amendments of 2000 emphasize the use of funds to address the service needs of racial and ethnic minorities who know they have HIV disease but are not receiving HIV/AIDS primary medical care.

A series of eight Reauthorization Issue letters were sent to grantees and Planning Councils by HAB/DSS in 2001-2003. These letters communicated expectations related to implementing changes required by the Ryan White CARE Act Amendments of 2000, including a letter on Unmet Need sent in May of 2003. The reauthorization letters, a copy of the Ryan White CARE Act as amended, DSS Program policy guidance documents and HIV/AIDS Bureau policies are available on the HAB website at www.hab.hrsa.gov

I.C.1 SPECIAL INITIATIVES

New Prevention Initiative

The Centers for Disease Control and Prevention (CDC) is refocusing some HIV prevention activities to reduce the number of new HIV infections in the U.S. More emphasis is being placed on: counseling, testing and referral for an estimated 180,000 – 280,000 persons who are believed to be infected but unaware of their HIV status; partner notification; prevention services for PLWH; and promoting routine and universal HIV testing as a part of prenatal care.

CDC's four strategies for accomplishing this include:

- Making HIV counseling and testing a routine part of medical care;
- Creating new models for diagnosing HIV infection, including rapid testing;
- Improving and expanding prevention services for persons living with HIV; and
- Decreasing perinatal HIV transmission.

Complete text of the strategy can be found in the April 18, 2003 MMWR or at www.cdc.gov/mmwr/pdf/wk/mm5215.pdf. The impact of this initiative will be reflected in the number of newly identified HIV-positive individuals who are made aware of their status and seek appropriate health care services.

In light of these new CDC Initiatives, which have the potential for identifying a significant portion of the 180,000 to 280,000 HIV infected individuals who are not now in care, HAB believes that it is incumbent upon all Title I grantees to fully reassess their priorities and allocations for services for FY 2004. Therefore, 2004 Title I applications should provide evidence of a greater emphasis, as demonstrated by increased allocation of funds for essential services, such as primary care, access to life prolonging medications and the provision of essential support services, which seek to identify, enroll and maintain HIV infected persons in systems of care.

Minority AIDS Initiative (MAI)

Since 1999, Congress has provided dedicated funds for the Minority AIDS Initiative (MAI) to expand or support new initiatives that are intended to reduce HIV-related health disparities and to improve HIV-related health outcomes for HIV-infected African Americans, Latinos, Native Americans, Asian Americans, Native Hawaiians, and Pacific Islanders. MAI funds are expected to expand or improve medical and support-service capacity in communities of color, and to expand or improve culturally and linguistically appropriate peer-treatment education to

individuals living with HIV. HRSA strongly encourages EMAs to recognize in their funding allocations the unique capabilities of minority providers in reaching communities targeted by the MAI funds.

MAI funding under Title I should support services specifically targeting racial and ethnic minority populations impacted by HIV/AIDS. Eligible entities may include: not-for-profit community-based organizations, national organizations, colleges and universities, clinics and hospitals, research institutions, State and local government agencies, tribal governments and tribal/urban American Indian entities and organizations.

Applicants should also refer to the HAB website for information and updates on program policy notices, www.hab.hrsa.gov

I.D. POST-AWARD RESPONSIBILITIES AND MONITORING

After the award of the FY 2004 grant, HRSA/HAB will monitor and assess how well the grant is administered, the effectiveness of the Planning Council in setting priorities and allocating funds, and the quality and availability of funded care and treatment services for HIV disease. Additional information will be requested in the Title I progress reports and through ongoing monitoring and communications with EMAs. Through these mechanisms, HRSA/HAB gathers information from EMAs regarding the required activities and program accomplishments.

The elements highlighted below are prerequisites for effective implementation of Title I programs and are the basis for monitoring and technical assistance activities.

- The EMA's ability to recruit and fill pivotal grantee and Planning Council positions as vacancies occur, and to provide leadership and adequate infrastructure in implementing the Title I grant. Grantee Project Director and Planning Council Chair positions should not remain vacant LONGER than three months. Persistent vacancies in these and other important grantee staff positions or the inability to provide adequate Planning Council support also will be considered in assessing the EMA's performance.

- The grantee's ability to promptly enter into signed service contracts. A review of required contract information submitted during the year will provide information as to whether an EMA was able to execute contracts within 60 days of the grant award. In addition, the timeliness with which the grantee executes contracts will be monitored on an ongoing basis through monitoring calls with project officers and site visits.

- Documentation of problems such as failure to pay service providers promptly, that impacts on service delivery.

- Documentation of a cooperative relationship between the Grantee and Planning Council in communicating with community-based organizations and consumer representatives. The EMA must demonstrate the ability to resolve conflicts, to ensure inclusiveness, and to provide information about programs.

- The overall responsiveness and effectiveness in implementing CARE Act reauthorization requirements.

- Efforts to ensure that both Planning Council priorities and the implementation of a continuum of care are responsive to the changing demographics and changing needs of those with HIV/AIDS, as evidenced by epidemiology data. Of special concern are addressing needs of people who know they have HIV disease but are not receiving HIV/AIDS primary medical care.

- Documentation of problems complying with HRSA program reporting requirements in a timely manner.

- The process used by grantees to monitor and assess the performance of service providers.

During the FY 2004 grant year, HRSA Project Officers will work closely with grantees on the activities described above. Lack of progress in correcting deficiencies in program administration or service delivery could result in special conditions on an EMA's FY 2005 Notice of Grant Award. Any special conditions issued will be subject to review with the FY 2005 application (See: Section IV.C.).

I.E. PURPOSES FOR WHICH TITLE I FUNDS MAY BE USED

LEGISLATIVE SUMMARY

Section 2605 (1) (A) *requires CEOs to provide assurances that "funds received in a grant under this part will be used to supplement and not supplant State funds made available in the year for which the grant is awarded and*
(B) that the political divisions within the eligible area will maintain the level of expenditures by such political subdivisions for HIV related services…(C) (5) that entities within the eligible area that will receive funds…shall participate in an established HIV community-based continuum of care…(C) (6) that funds received in a grant under this part will not be utilized to make payment for any item or service to the extent that payment has been made or can reasonably be expected to be made…(7)(A) HIV health care and support services provided with assistance made under this part will be provided without regard (i) to the ability of the individual to pay for such services and (ii) to the current or past health condition of the individual to be served.
Section 2605 (e) *describes the requirements regarding imposition of charges for services.*

For complete details on allowable uses of funds and funding restrictions, please refer to the Grant Administration chapter of the Title I Manual on the HRSA/HAB website www.hab.hrsa.gov/CATIE.

I.F. REPORTING REQUIREMENTS

FY 2004 Program Progress Reports

EMAs must report to the HRSA Grants Management Office their progress in accomplishing Title I funded program activities and services in accordance with applicable provisions of the general regulations (45 CFR Part 92,Sub-part C, Monitoring and Reporting of Program Performance), and in accordance with the CARE Act. Guidance in preparing FY 2004 program progress reports will be provided to grantees under separate cover.

Reporting on Funding for Women, Infants, Children and Youth

EMAs are required by the CARE Act to provide HIV/AIDS health and support services for women, infants, children, and youth, based on the percentage that they represent in the total population of people living with AIDS. This requirement is subject to audit and therefore, grantees must utilize a consistent system and method for documenting expenditures for each priority population. Also, as in the past, services directed to infants, children, youth, and women must be funded in accordance with the service priorities established by the Title I Planning Council. However, due to the continuing expansion of the HIV epidemic among youth and women — especially women of color — it is the intent of Congress to assure the availability of, and access to, primary medical care and health-related supportive services for these four specified populations.

The CARE Act Data Report

EMAs are required to submit *CARE Act Data Reports (CADR)* from all funded providers to the Office of Science and Epidemiology (OSE), HRSA/HAB/OSE. The CADR documents services provided, demographic characteristics of clients receiving those services, and descriptive information about the organizations that deliver care with Title I funds. The CADR can be entered directly through the HRSA/OIT website www.hab.hrsa.gov by the grantee of record or each service provider. The grantee will be responsible for reviewing all contracted service providers' data reports online for accuracy and completeness before submitting reports to OSE. Instructions for completing the report online are located on the HAB website. Alternatively, the CADR may be submitted on paper forms provided by OSE for this purpose. **CADR information for the calendar year FY 2003 must be reported no later than March 15, 2004.**

The requirements to collect the data necessary to complete the CADR must be included in all contracts with service providers. Grantees should note that the CARE Act stresses the importance of quality management and improved health outcomes in HIV programs. The collection and management of unduplicated client-level data are central to efforts in managing patient-care services and evaluating care that is provided. **HAB therefore strongly encourages providers to collect and maintain unduplicated client-level data to be used to create aggregate counts for the purpose of data reporting. To assist in unduplicated client-level data management, HAB is offering a free software package called RWCAREWare, which is available for download at www.hab.hrsa.gov/tools.htm. Use of RWCAREWare is not required**

Title I Allocations Reports

Grantees are required to submit reports on planned and final allocations of all Title I funds awarded to the EMA within a specific timeframe as a condition of award.

Planned Allocations: Grantees are required to submit a report listing their planned allocations, by service category, within 90 days of receiving their grant award.

Final Allocations: Grantees must submit a report listing their final funding allocations within 90 days following the end of the grant year.

Planned and final allocation reports must be submitted **both as hard copies and via electronic template**. The electronic copy must be submitted by email to DSSDIVSERV@HRSA.GOV. The file attachment must include the name of the EMA in the title. For example: Miami Florida would submit a completed allocations report entitled <miamidadeFY2003FinalAllocations>. This will enable the proper routing of the submission by the DSSDIVSERV system.

SECTION II:

FILING THE FY 2004 APPLICATION

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II.A APPLICATION DEADLINE AND FILING INSTRUCTIONS

The deadline for submitting a completed Ryan White CARE Act Title I Grant Application is **Friday October 24, 2003**. Applications must be received by 5:00 p.m. Eastern Time.

Complete submissions must include the original application, two copies and one diskette or CD ROM copy.

No extensions to the FY 2004 Title I grant application deadline will be permitted.

Submit the FY 2004 Title I Grant Application to the address indicated in the box below.

SEND APPLICATIONS TO:
HRSA Grants Application Center
Legin Group, Inc.
901 Russell Avenue, Suite 450
Gaithersburg, MD 20879
1(877) 472-2123

Note the contents, as follows, on the outside of the envelope:
"Ryan White CARE Act Title I Application (CFDA 93.914)"

Applicants should note that HRSA anticipates accepting grant applications online in the last quarter of the Fiscal Year (July through September). Please refer to the HRSA grants schedule at http://www.hrsa.gov/grants.htm for more information.

For Further Information on Application

For further information about grant administration or fiscal issues related to the Title I grant, contact Ms. Helen Harpold, Grants Management Specialist at (301) 443-3262, (hharpold@hrsa.gov).

Please direct any requests for program information or technical assistance to:

Douglas H. Morgan, M.P.A.
Director, Division of Service Systems
5600 Fishers Lane, Room 7A-55
Rockville, Maryland 20857
Tel: (301 443-6745
FAX: (301) 443-8143
dmorgan@hrsa.gov

II.B HOW TO PREPARE THE TITLE I APPLICATION

The FY 2004 Title I grant application must be prepared using the PHS Grant Application PHS 5161-1 (revised 7/00) which includes Standard Form (SF) 424 and related forms for budget and staffing requests. These forms are available on the HRSA Program Support website. In addition, the application must include a narrative and accompanying tables as described in this Guidance, a signed copy of the program assurances, and supporting documentation in the form of attachments. See the checklist at the end of this section for instructions on where to place these items in the final application package.

Resources on the Internet

The PHS 5161-1 is available on the HRSA Program Support website: http://forms.psc.gov This *Application Guidance* also is available on the HIV/AIDS Bureau website: www.hab.hrsa.gov.

In preparing the FY 2004 Title I Application, please adhere to the following technical guidelines:

- Applications must be in English.
- Submit the original copy of the application UNBOUND.
- Include 2 copies of the application, and a diskette or CD ROM with electronic files of both the narratives and tables in MS Word.
- Use a standard size black type that does not exceed 12 characters per inch.
- Use 8.5" by 11" inch paper that can be photocopied.
- Ensure that margins are not less than one inch each.
- Use 1.5 or double-spaced lines in the text.
- Submit a summary description, EMA map, and table of contents at the beginning of your application, as indicated in the Application Checklist.
- Starting with Section III (Formula Request for Funding), number all pages of the application consecutively.
- The Formula and Supplemental Requests for Funding (excluding attachments) may not exceed a total of 115 pages.
- The Supplemental Request for Funding narrative may not exceed a total of 65 pages (excluding tables, Federal forms, and attachments).

- Do not submit double-sided copies. (Copy double-sided Federal forms on two pages; however, do not reproduce the second side of a Federal form if it only provides instructions).

- Do not use photo reduction or include photos, pamphlets, or over-sized documents.

- Include all Tables as Attachment 1 of the application.

In addition, applicants are urged to consider the following recommendations provided by program officials and reviewers from previous grant review committees

- Follow the written instructions in the Guidance carefully and completely. Put required information in the sections specified in the Guidance.

- Use the Checklist (located below) to organize the application, to plan and monitor application preparation and to verify completion of all materials before submission.

- Keep in mind when responding to questions in each sub-section that the application will be read as a single narrative document. Make sure the information is consistent throughout and that what is reported in one section correlates with other, relevant sections.

- Provide accurate and honest information. A candid account of problems and creative plans to address them is better than glossing over potential problems.

- In order to standardize and condense the way information is presented and facilitate the application review process, use the tables provided (where indicated) to present the requested information.

- Eliminate potential internal inconsistencies by ensuring that the information provided in each table is consistent with the narrative and information included in other tables.

- If you omit any required information or data, explain why.

- The use of locally derived epidemiology or any other data must be described appropriately in the text and the tables.

- Where instructed in the Guidance, provide the specific documentation requested (e.g., By-laws or Intergovernmental Agreements).

- Do not use attachments for information that is required in the body of the application. Only use attachments for the purposes specified in the Guidance.

- Prepare the application with the reader in mind:

a. by including the requested table of contents;
b. by cross-referencing all tables and attachments in the text of the application;
c. by carefully proofreading;
d. by numbering all pages consecutively as instructed; and
e. by providing all requested information in the sequence and format requested in this Guidance.

II.C. APPLICATION CHECKLIST

The following checklist is provided to ensure that all required narrative information and tables are included with the application

TITLE I FY 2004
APPLICATION CHECKLIST

____ **Title Page**
____ Table of Contents

____ **FEDERAL FORMS: PHS GRANT APPLICATION, FORM PHS 5161-1 (REVISED 7/00)**

(The pages of this section of the application should be numbered separately from the remainder of the application (i.e., i, ii, iii, etc.))

____ SF 424: Application for Federal Assistance, signed Face page, and letter updating the name and title of the authorized representative of the applicant EMA
____ SF 424-A: Budget Information -- Non-construction Programs
____ Section-A: Budget Summary (CFDA: 93.914)
____ Section-B: Budget Categories
____ Section-C: Non-Federal Resources (DO NOT COMPLETE)
____ Section-D: Forecasted Cash Needs (DO NOT COMPLETE)
____ Section-E: Budget Estimates for Balance of Project (DO NOT COMPLETE)
____ Budget Narrative/Justification
____ SF 424-B: Assurances—Non - Construction Programs (Signed)
____ PHS 5161-1 Certifications -- Debarment and Suspension, Drug-Free Workplace, Lobbying, Program Fraud, and Certification Regarding Environmental Tobacco Smoke (Signed)
____ Checklist from PHS 5161-1 Application Kit, Page 25. The name, address, and telephone number should be provided for both the individual responsible for day-to-day program administration and the finance officer
____ Intergovernmental Review under Executive Order (EO) 12372 if required by the State

____ **Formula Funding Request**
[Starting here, number all pages consecutively, beginning with page 1.]

____ 1. Measuring Unmet Need (Narrative)

____ 2. EMA HIV/AIDS Epidemiology

____ 3. Progress in Implementing the FY 2003 Plan
____ Accomplishments to Date (Narrative)
____ Current Challenges (Narrative)

____ 4. HIV Health Services Planning Council
____ Planning Council Representation and Reflectiveness (Narrative)
____ Planning Council Member Vacancies (Narrative)
____ Planning Council Training (Narrative)

____ 5. Letter of Assurance from Planning Council Chair(s)
____ Assurance of FY 2003 Expenditure of Funds
____ Assurance that FY 2003 Conditions of Award Have Been Addressed
____ Assurance of FY 2004 Priority Setting and Allocation of Funds
____ Assurance on Planning Council Member Training

____ 6. Maintenance of Effort Documentation

____ 7. FY 2004 Agreements and Compliance Assurances and Intergovernmental Agreement(s)

____ **Supplemental Funding Request**
(The narrative for this section is limited to 65 pages. Completed tables are to be included in Attachment 1.)

____ 1. Description of the EMA and Map of the EMA

____ 2. Compliance with FY 2002 and 2003 Title I Requirements and Conditions of Award

____ 3. Grantee Administration and Accountablity
____ Fiscal and Program Monitoring (Narrative)
____ Third Party Reimbursement (Narrative)
____ Audit Requirements
____ Administrative Assessment

____ 4. Severe Need
____ HIV/AIDS Epidemiology (Narrative)
____ Cost and Complexity of Providing Care (Narrative)
____ Assessment of Populations with Special Needs
____ Unique Service Delivery Challenges (Narrative)

____ 5. Impact of Title I Funding
____ Continuum of Care (Narrative)
____ The EMA's System for Accessing Care (Narrative)
____ Coordination of Services and Funding Streams (Narrative)

____ 6. Planning Council Mandated Roles and Responsibilities
____ Comprehensive Plan (Narrative)
____ Data/Information Used for Priority Setting and Allocation of Funds (Narrative)
____ Compatibility with the SCSN (Narrative)
____ Planning Council Assessment of the Administrative Mechanism (Narrative)

____ 7. Quality Management Programs and Outcome Evaluation Activities
____ Quality Management Activities during the FY 2003 Grant Year (Narrative)
____ Use of Costs in Evaluating Services (Narrative)
____ Progress in Developing Outcome-based Service Evaluation (Narrative)

____ 8. Plan for FY 2004
____ Service Goals and Objectives
____ Providing Access and Reducing Disparities (Narrative)

____ 9. Proportional Resource Allocation for WICY
____ Planning Council Prioritization (Narrative)
____ Coordination (Narrative)
____ Progress in Implementing Tracking Requirements (Narrative)
____ Plan for FY 2004 (Narrative

____ **Tables**
____ Table 1: AIDS Incidence, AIDS Prevalence and HIV (not AIDS) Prevalence by Demographic Group and Exposure Category
____ Table 2: Roster of FY 2003 Title I Planning Council Members
____ Table 3: Matrix for Planning Council Membership Categories
____ Table 4: Reflectiveness of Non-Conflicted Consumers and Planning Council by Demographic Group
____ Table 5: Grantee Monitoring of Subgrantees/Contractors
____ Table 6: Co-Morbidity, Poverty, Insurance Status and Medicaid Coverage
____ Table 7: Assessment of Populations with Special Needs
____ Table 8: Data/Information Used for Priority Setting and Allocation of Funds
____ Table 9: Title I Funding in the Context of Other HIV Service Funding
____ Table 9: Summary of Priority Services to be funded in FY 2004
____ Table 10: FY 2004 Implementation Plan
____ Table 11: Summary of Priority Services Funded in FY 2003 and to be Funded in FY 2004

____ **Diskette or CD-ROM containing the following documents in MS Word**
____ Formula Application
____ Supplemental Application
____ Attachment I: All Tables

SECTION III:

INSTRUCTIONS
FOR FORMULA FUNDING

SECTION III:
INSTRUCTIONS FOR FORMULA FUNDING

III.A. PREPARING THE FORMULA APPLICATION

This section includes a description of the legislative, program requirements and instructions for submitting a request for Formula funds. Please refer to the Checklist on page 18 of the Guidance for the order in which the information should be presented in the application.

EMAs are entitled to receive a formula grant based on an adequate response to the documentation required in this section. The Formula funding portion of the FY 2004 application requires documentation of the following legislative and program requirements.

III.B. FORMULA FUNDING: THE REVIEW PROCESS

The amount of Title I formula funds awarded to an EMA will be based upon relative need as reflected in the Congressionally mandated formula. Information from Section III will be reviewed for completeness and responsiveness to the narrative and tables.

EMAs that do not submit required documentation under Section III will not receive formula funds and are therefore not eligible for Supplemental Funds.

III.C. Measuring Unmet Need Using the Framework Method

LEGISLATIVE SUMMARY

Section 2602(4)(B)(i) individuals with HIV disease who know their status and are not receiving HIV-related services.
Section 2602(D)(i) includes a strategy for identifying individuals who know their HIV status and are not receiving such services and for informing the individuals of and enabling the individuals to utilizes the services.

HRSA/HAB supports ongoing efforts to develop methods to assist States and EMAs in assessing unmet need for persons who know their HIV status but are not receiving primary medical care. The unmet need requirement is a provision in the CARE Act. CARE Act grantees and planning bodies can use the Unmet Need Framework to estimate how many PLWH who know their status (HIV-positive/aware individuals) in a jurisdiction are "in" and "out" of HIV primary medical care. Those who are "out of care" constitute your jurisdiction's estimate of unmet need**.**

Narrative

Complete a narrative that outlines your plans for determining Unmet Need for primary medical care. This narrative should include potential data sources for completing the framework, the timeline and personnel involved in the process.

III.D. EMA HIV/AIDS EPIDEMIOLOGICAL DATA

(Table 1, Narrative is required IF HIV (not AIDS) Prevalence data used are not CDC estimates)

The use of HIV/AIDS epidemiology data is key to development of the comprehensive plan, identifying characteristics of the EMA's HIV/AIDS cases, conducting a needs assessment, and establishing priorities for the allocation of funds. Among the most important epidemiology data for use in CARE Act planning is AIDS prevalence data (the number of persons living with AIDS) and HIV prevalence data (the number of persons living with HIV; non-AIDS). HAB/DSS expects grantees and Planning Councils to monitor recent trends in HIV/AIDS epidemiology data and to determine service priorities and funding allocations consistent with this data. Chapter 3 in the Joint Epidemiological Profiles should assist you in completing the tables.

Narrative

An EMA may elect to utilize local data sources instead of CDC estimates, if HIV is not a reportable disease, or if HIV reporting has been recently implemented within the EMA. Those EMAs that do not use CDC estimates must provide a narrative explaining their use of local data.

Provide a brief narrative description responding to the following questions.

- What is the rationale for using the data set?
- What type of local data, i.e., sentinel, needs assessment, is used to generate information on HIV prevalence (not AIDS) in the EMA?
- What methodology is used to calculate HIV (not AIDS) prevalence in the EMA?
- Is the data source less than 3 years old? When was the data collected?
- Has a comparison of local data against CDC estimated data been completed? What were the results?

Table

Using Table 1, applicants must submit a summary report on AIDS Incidence (cases diagnosed from 01/01/01 through 12/31/02) and both HIV and AIDS Prevalence (cases diagnosed as of 12/31/2002) for the EMA. A report on both HIV and AIDS prevalence and incidence was prepared by CDC and is included in the guidance in Appendix 4.

Completed tables should be placed in Attachment 1 of the application.

III.D. PROGRESS IN IMPLEMENTING THE FY 2003 PLAN

The purpose of this section is to provide information regarding accomplishments and challenges in implementing the FY 2003 Title I plan. This section of the application also serves as the mid-year FY 2003 Program Progress Report.

LEGISLATIVE SUMMARY

Section 2603(c) *requires applicants to demonstrate that . . .grants made to the area for the preceding fiscal year were expended in accordance with the priorities. . . that were established by the Planning Council serving the area.*
Section 2601(a) *limits the awarding of funds to eligible areas whose application under section 2605 (b) contains a report concerning the dissemination of emergency relief funds under subsection (a) and the plan for utilization of such funds.*

Table

Submit an updated and approved version of Table 10 (the FY 2003 Implementation Plan) showing spending and service utilization through July 31, 2003.

Narrative

Please provide a brief narrative of the following:

Accomplishments to Date

Using the objectives outlined in Table 10 of the FY 2003 application, identify program accomplishments from March 1, 2003 through July 31, 2003. Specifically, address how these objectives helped increase access to the continuum of care and maintain clients in care.

Current Challenges

Identify current challenges in providing HIV/AIDS services with a special focus on ongoing efforts to implement FY 2003 goals and objectives, program and fiscal administration and Planning Council's roles and responsibilities. The narrative should address:

- challenges/barriers to accomplishing the goals set forth in your plan;
- plans to meet the challenges/overcome barriers; and
- progress to date.

Indicate whether or not there is a need for technical assistance. *(Please note that a formal request for technical assistance must be submitted to your DSS Project Officer.)*

III.E. HIV HEALTH SERVICES PLANNING COUNCIL

(Tables 2, 3, 4 and narrative)

LEGISLATIVE SUMMARY

Section 2602(b)(1) *requires that the Planning Council "reflect in its composition the demographics of the epidemic in the eligible area...with particular consideration given to disproportionately affected and historically underserved groups and subpopulations."*
Section 2602(b)(2) *requires certain categories of representatives to be members of the Planning Council.*
Section 2602(b)(5)(C) *requires that not less than 33 percent of the Planning Council consist of infected and affected individuals who are consumers and not aligned with providers of Title I-funded HIV services.*
Section 2602(b)(7) *requires that Planning Council meetings be open to the public, that adequate notice be given to the pubic regarding meeting times, and that Planning Council records, reports, transcripts, minutes, agenda or other documents be made available for public inspection and copying at a single location. It specifies that minutes be kept and certified by the Chair(s) of the council. It requires that in providing this information to the public, efforts be made to protect personal privacy in regards to medical information or personnel matters.*
Section 2603(b)(1)(F) *requires grantees to demonstrate the inclusiveness of Planning Council membership, with particular emphasis on affected communities and individuals with HIV disease.*
Section 2602(e) *requires that the Secretary provide to each CEO guidelines and materials for training members of Planning Councils regarding the duties of the Council.*

Title I HIV Health Services Planning Councils are comprised of volunteers, appointed by the CEO, who plan for the use of Title I funds to support HIV services in the EMA. The CARE Act and HAB/DSS policy require that Planning Council composition reflect the demographics of the HIV/AIDS population in the EMA. The CARE Act requires that 33 percent of members be non-aligned consumers of Title I services. In addition, CARE Act legislation requires that certain categories of representation be present on all Planning Councils and that PLWH have full and effective involvement. Planning Council deliberations must be open and fully accessible to the public. Members must be trained to fully and effectively participate on Planning Councils.

Grantees and Planning Councils must demonstrate reasonable efforts to establish and sustain reflectiveness. As of March 1, 2004, non-aligned consumer (PLWH) membership must reflect prevalence of HIV disease (HIV Prevalence (not-AIDS) + AIDS Prevalence). EMAs must use the prevalence of HIV disease (HIV Prevalence (not-AIDS) + AIDS Prevalence) data to report on the composition of the Planning Council. EMAs also should use HIV prevalence data in their planning activities and in establishing Planning Council membership.

In order to have an effective planning body, members must be trained regarding their legislatively mandated responsibilities, as well as other competencies necessary for full participation in collaborative decision-making. HAB/DSS has provided a variety of written informational and training materials to planning bodies, including:

- Title I Manual;
- Title II Manual;
- ADAP Manual;

- Consumer Digest (PLWH Sourcebook);
- Training Guide, A Resource for Orienting and Training Planning Council and Consortia Members;
- Planning Council Primer;
- Outcome Evaluation Guides;
- Self Assessment Modules;
- Needs Assessment Guide; and
- A Practical Guide to Measuring Unmet Need for HIV-Related Primary Medical Care

These materials were updated to reflect recent legislative changes in the CARE Act and are available on the HAB website www.hab.hrsa.gov. The CEO and Council Chair(s) must provide assurances with this application that training activities will take place. EMAs should use these resources as they become available (along with locally developed materials) to ensure that members are knowledgeable about their roles and duties on the Planning Council. HAB/DSS is in the process of developing a standard curriculum and new methods for providing ongoing and consistent training for Planning Council leadership and members. A separate budget line item for training must be included in the Planning Council Support budget.

Tables

Using Tables 2, 3, and 4, applicants must document an established, functioning HIV Health Services Planning Council that meets CARE Act and HRSA/HAB program requirements. Information for these tables must be based on the composition of the Planning Council membership as of September 1, 2003, and Planning Council reflectiveness must be based on the prevalence of HIV disease (AIDS prevalence + HIV prevalence (not AIDS) data submitted in Table 1 of the application.

Narrative

Provide a narrative addressing the areas listed below.

- Based upon information provided in Tables 1, 2, 3, and 4, describe any deficiencies in representation or reflectiveness of Planning Council membership. Describe variations in the past two years between the overall demographics of the Planning Council and HIV disease prevalence demographics of the EMA. Explain why these deficiencies persist. Provide a plan and timeline for addressing each deficiency.

- Based upon information provided in Tables 1, 2, 3, and 4, describe any deficiencies in representation or reflectiveness among non-aligned consumer Planning Council members. Note variations between the demographics of the non-aligned consumers and the HIV disease prevalence of the EMA. Provide a plan and timeline for addressing each deficiency.

- Describe any vacant seats on the Planning Council. Explain how long the seats have been vacant and why the vacancies exist. Provide a plan and a timeline for addressing each vacancy.

- Describe how new and continuing Planning Council members were trained in FY 2003. Specifically describe how PLWH are trained and supported in their role as Planning Council members.

Definition of key terms used to describe reflectiveness

Representation:	Refers to the fifteen (15) legislatively defined categories of membership listed in the instructions for Table 2 in the Guidance
Reflectiveness:	Refers to the degree to which Planning Council membership and non-aligned PLWH membership are similar to the demographics of the epidemic in the EMA.
Demographics:	Characteristics of the local PLWH population including gender, race/ethnicity, age and exposure category.
Non-aligned:	Having no financial or governing interest in Title I-funded agencies.

III.E. LETTER OF ASSURANCE FROM PLANNING COUNCIL CHAIR(S)

(Provide requested letter)

Applicants must provide a letter of assurance signed by the Planning Council Chair(s). The letter must include the following:

- An assurance by the Planning Council Chair(s) that FY2003 formula and supplemental funds awarded to the EMA are being expended according to the priorities established by the Planning Council;

- An assurance by the Planning Council Chair(s) that all Planning Council-related FY 2003 Conditions of Award, for both formula and supplemental grants, have been addressed;

- An assurance that the FY 2004 priorities listed in Table 11 were determined by the Planning Council, and that the process for establishing those priorities (as described in Section IV.C.5) was used by the Planning Council; and

- An assurance that Planning Council membership training took place according to plan.

III.F. MAINTENANCE OF EFFORT

(Submit required documentation)

LEGISLATIVE SUMMARY

Section 2603(b)(1)(C) *requires that grantees demonstrate the commitment of local resources, both financial and in-kind, to combating the HIV epidemic.*
Section 2605(a)(1)(B) *requires "that the political subdivisions within the eligible area will maintain the level of expenditures by such political subdivisions for HIV-related services for individuals with HIV disease at a level that is equal to the level of such expenditures by such political subdivisions for the preceding fiscal year."*
Section 2605(a)(1)(C) *requires "that political subdivisions within the eligible area will not use [Title I funds]... in maintaining the level of expenditures for HIV-related services."*

To be eligible to receive Title I funding, grantees must maintain a commitment of both financial and in-kind resources for HIV-related services by local governments within the EMA at a level equal to that of the preceding fiscal year. The *HAB/DSS Maintenance of Effort Issue Paper* for Title I Programs describes requirements in detail. If you do not have a copy of this paper, please contact your Project Officer to request one. Information is also available in Section II (4) of the Title I Manual.

Required Documentation

Applicants must submit the following with their FY 2004 Title I application:

- an assurance, signed by the CEO, stating that the EMA is complying with the maintenance-of-effort requirement, as required under the assurances section (See Appendix 1)

- a written description of the methodology used to track and report on maintenance of effort;

- a report detailing year-to-year HIV-related expenditures by local governments within the EMA for the previous two complete fiscal years. The report must include: (1) a brief narrative explaining any changes in the data set where HIV-related expenditures have been reduced or where the purpose of an HIV-related expenditure has changed; and (2) documentation proving that the overall level of HIV-related expenditures has been maintained year-to-year for the previous two complete fiscal years (2001 and 2002).

III.G. FY 2004 AGREEMENTS, COMPLIANCE ASSURANCES, AND INTERGOVERNMENTAL AGREEMENT(S) (IGAS)

Agreements and Compliance Assurances

A signed copy of the *FY 2004 Agreements and Compliance Assurances* must be submitted with the application. (See Appendix 1) This form must be signed by the CEO of the EMA, or the individual with signature authority delegated by the CEO. In the latter instance, a letter documenting the delegation of authority must be submitted with the application. This letter may be from a previous year but must be valid for the current application period.

Intergovernmental Agreements

The CARE Act requires all EMAs to establish intergovernmental agreements (IGAs) with each political subdivision within the EMA that meets both of the following criteria: 1) the subdivision provides HIV-related health services; and 2) the subdivision has 10 percent or more of the total reported AIDS cases in the EMA over the previous 5-year period ending December 31, 2000.

A copy of all IGAs must be submitted with the application. A listing of political subdivisions that meet the 10 percent threshold, as well as a listing of geographic definitions for EMAs, can be found on the HAB website at: http:www.hab.hrsa.gov/grant.htm If those subdivisions do not provide HIV-related health services, an IGA is not required.

The IGAs must include a description, justification and the method used to allocate funds among the political subdivisions. The justification should be explained in terms of 1) the number of AIDS cases; 2) the severity of need for outpatient and ambulatory care services; and 3) health and support personnel needs. Future application guidance will require the severity of need among political subdivisions to be explained in terms of those persons in care whose needs are not being met and those who know their HIV status but are not receiving HIV/AIDS primary medical care.

SECTION IV:

INSTRUCTIONS FOR SUPPLEMENTAL FUNDING

SECTION IV:
INSTRUCTIONS FOR SUPPLEMENTAL FUNDING

IV.A. PREPARING THE SUPPLEMENTAL APPLICATION

Section IV of the Guidance outlines the information required for the supplemental funding request. The information requested directly relates to legislative requirements and program expectations for recipients of Ryan White CARE Act Title I funds. Applicants should use tables and narrative text as instructed to provide the required information. The tables to be included as Attachment 1 of the application are used to standardize information across EMAs.
The FY 2004 Guidance requires applicants to demonstrate that the EMA engages in a planning process based on a strong understanding of HIV/AIDS-incidence and prevalence data. In responding to questions in each sub-section, applicants should keep in mind that the application is a single narrative document. Therefore, all sections must correlate with each other.

(PLEASE NOTE: The Supplemental Funding Request, Section IV, is limited to a maximum of 65 pages, excluding tables.)

IV.B. THE REVIEW PROCESS

Review of the FY 2004 Supplemental applications will be supervised by HRSA's Division of Independent Review and scored based upon the evaluation criteria in Section IV.C.1 and submission of the table and narrative information in Section IV.C.2. through IV.C.8. Scores assigned by reviewers are a principal factor in determining the level of an applicant's supplemental grant amount. The amount of Title I supplemental funds awarded to an EMA will depend on the amount of the FY 2004 appropriation, the relative need in the EMA as reflected in the Congressionally-mandated formula used to determine the Title I formula award, the amount of supplemental funds available after requirements in the formula award have been met, and the applicant's numerical score on the supplemental application as determined by the review process. **In addition, HRSA reserves the right to offset FY 2004 awards with unexpended balances from previous years.** Point values have been assigned by HAB/DSS to the required sections for use by the reviewers in scoring the application. The following table lists the maximum number of points awarded for each category.

1. Compliance with FY 02-03 Requirements and Conditions of Award	26 Points
2. Grant Administration and Accountability	10 Points
3. Severe Need	33 Points
4. Impact of Title I Funds	5 Points
5. Planning Council Mandated Roles and Responsibilities	8 Points
6. Update on Assuring Quality of Services and Evaluation Activities	5 Points
7. Plan for FY 2004	8 Points
8. Women, Infants, Children and Youth	5 Points
MAXIMUM TOTAL:	**100 Points**

IV.C. SUMMARY OF REQUIRED INFORMATION

IV.C.1 COMPLIANCE WITH FY 2002 AND FY 2003 TITLE I REQUIREMENTS AND CONDITIONS OF AWARD (COA) AS PREVIOUSLY SUBMITTED ……..(26 Points)

The purpose of this section is to assess the EMA's compliance with conditions of the grant award for prior years.

Points for this section will be assigned based on the timeliness of COA submissions by the grantee to the HRSA/HAB Grants Management Officer. FY 2004 grant awards will not be issued to an EMA that is not in full compliance with FY 2003 and all the conditions established in the previous years.

Note: **None of the materials listed on the table below need to be resubmitted as a part of the application. The score the EMA receives will be based on materials already submitted.**

FY 2002 COMPLIANCE ISSUES	Due Date	Point Values	Comments
REPORTING REQUIREMENTS			
FY2002 Final Financial Status Report (FSR), received by the due date or approved extension due date.	6/2/03	1-If recd. By due date	Requests for late submission must be recd. no later than 6/2/03. Final FSRs recd. after 9/30/03 will be considered late.
FY2002 Expenditure Rate (as documented in the final FSR)		5 – 95% 4 – 94% 3 – 93% 2 – 92% 1 – 91% 0 – 90% or less	No points for an interim FSR. Points awarded based on percentage of funds expended.
FY2002 Final Progress Report, Received by the due date or approved extension due date.	6/2/03	1 – if recd. by due date	Requests for late submission must be recd. no later than 6/2/03.
FY2002 COA F.3 Final Minority AIDS Initiative (MAI) Report	5/30/03	1 – if recd. by due date	
FY2002 COA G WICY Report	7/1/03	1 – if recd. by due date	
FY2003 COMPLIANCE ISSUES			
COA A.2 Revised budgets and narrative	4/16/03	1 – if recd. by due date 1 – if removed by 10/15/03. Maximum – 2 pts.	Based on total funding for FY2003

COA B Planning Council Reflectiveness	4/16/03	1 – if recd. by due date & in Compliance 1 – if removed by 10/15/03. Maximum – 2 pts.	
COA C.1 FY2002 Final Allocation Table	5/1/03	1 – if recd. by due date 1 – if removed by 10/15/03. Maximum – 2pts.	
COA C2-4 FY2003 Planned Allocations, PC letter, revised Table 10	6/16/03	1 – if recd. by due date 1 – if removed by 10/15/03. Maximum – 2 pts.	Must include amount allocated to each category and priority number as determined by the Planning Council
COA D1-4 Contract Review Certification for each grant-funded contract and Attachment F	7/31/03	2 – if recd. by due date 1 – if removed by 10/15/03. Maximum – 3 pts.	
COA E.1 MAI Plan FY2003, including summary, report format and narrative	6/16/03	1 – if recd. by due date 1 – if removed by 10/15/03. Maximum – 2 pts.	
COA E.2 MAI Interim Report	10/1/03	1 – if recd. by due date 1 – if removed by 10/15/03. Maximum – 2 pts.	
COA G Local Pharmacy Assistance Report	7/31/03	1 – if recd. by due date 1 – if removed by 10/15/03. Maximum – 2 pts.	
Special Conditions of Award (for conditions due by 10/01/03)	See Notice of Grant Award	-1 if not received by due date -1 for conditions not lifted by 10/15/03	

IV.C.2 DESCRIPTION OF THE EMA AND MAP

Applicants are required to include a one-page description and map of the EMA with their application. The **description and map will not be scored**, but will be used to provide reviewers — who will be scoring the application — with a context for the information presented by the grantee. The description of the EMA may be single-spaced. At a minimum, the following should be discussed:

- general demographics of the EMA;
- demographics of the HIV/AIDS populations;
- geography of the EMA with regard to communities affected by HIV/AIDS and the location of HIV/AIDS services in relation to those communities;
- a description of the continuum of care offered in the EMA, including relevant information about the primary medical care services and how HIV primary care services are delivered and how clients are supported in treatment.

In addition to the description, applicants are required to provide a map of the EMA that shows the location of HIV/AIDS primary medical care, support services and points of entry.

IV.C.3 GRANTEE ADMINISTRATION AND ACCOUNTABILITY ……10 POINTS
(Table 5 and narrative)

The purpose of this section is to demonstrate the extent to which the CEO in each EMA has met the legislative requirements to disburse Title I funds quickly, closely monitor their use, and ensure that the CARE Act is the payer of last resort.

HAB expects grantees to be accountable for the expenditures of funds awarded under Title I. The OMB Program Assessment Rating Tool (PART) for the HRSA and draft OIG report on DSS grantee monitoring of subgrantees have both been highly critical of the stewardship of Title I funds by grantees. Thus, a higher priority has been given in the supplemental portion of the grant to the ability of grantees to demonstrate outstanding monitoring of subgrantee performance and accounting procedures and which ensure that Title I funds are payer of last resort.

This section describes how Title I funds are administered in the EMA. Using Table 5 and addressing the questions in the narratives below, provide information on fiscal and program monitoring, subcontractor compliance with audit requirements, third-party reimbursement, client-eligibility screening, and Planning Council assessment of the administration mechanism.

Table

Complete Table 5.

Fiscal and Program Monitoring

Narrative

Grantees are expected to monitor fiscal and programmatic compliance with contracts and other agreements for HIV/AIDS services in the EMA. The narrative should address the following questions:

Fiscal Monitoring: Describe the process of corrective action once a fiscal-related concern is identified.

Program Monitoring: Describe the process of corrective action once a programmatic concern is identified.

Attach a copy of the most recent site-visit monitoring tool used by the grantee for fiscal and programmatic monitoring of funded service providers.

Third Party Reimbursement

Grantees are encouraged to make effective use of strategies to coordinate between Title I and third-party payers who are ultimately responsible to pay the costs of services provided to eligible or covered persons. Third party payer sources include Medicaid, State Children's Health Insurance Programs (SCHIP), Medicare and private insurance. Grantees and their subcontractors

who provide Medicaid-covered services must be Medicaid certified. CARE Act funded services may not be used to pay for Medicaid covered services for Medicaid beneficiaries.

Narrative

- Describe the process that the grantee uses to ensure that all service providers are Medicaid eligible.
- Explain how subcontractors document and ensure that clients have been screened for eligibility for Medicaid, Medicare, Veterans benefits, private health insurance or other programs to ensure that CARE Act funds are the payer of last resort.
- Describe the relationship between the grantee and contractors on monitoring third party reimbursement. Is this relationship defined in service contracts?

Audit Requirements

The grantee must ensure that contractors and other service providers comply with the audit requirement in OMB Circular A-133. Complete questions on audit requirements in Table 5.

Administrative Assessment

Complete questions on assessment of the administrative mechanism in Table 5.

Narrative

A narrative is only required if deficiencies were noted by the Planning Council in its most recent evaluation of the administration of the Title I Grant in terms of activities, such as timely payments to contractors or data collection. Describe any recommended corrective action and suggested methods of improvement. Explain the current status of response to these recommendations.

IV.C.4 SEVERE NEED……33 POINTS
(Tables 1, 6, 7 and narratives)

In this section applicants are asked to describe the severity of the HIV/AIDS epidemic in the EMA and to explain why CARE Act supplemental funding for health services is needed to provide necessary services to people living with HIV in the EMA, including traditionally underserved populations. To the extent possible, applicants should quantify both the service needs of those PLWH receiving HIV/AIDS primary medical care and those who know their HIV status but are not presently in the system of HIV/AIDS primary medical care. Points will be awarded based on submission of completed tables and fully responsive narratives.

LEGISLATIVE SUMMARY

Section 2603(b)(1)(B) *requires EMAs to submit an application for funding "that demonstrates the severe need in such area for supplemental financial assistance to combat the HIV epidemic."*
Section 2603(b)(1)(B) *requires that "the amount of each grant made for purposes of this subsection shall be determined by the Secretary based on a weighing of factors…with severe need…counting one-third."*
Section 2603 (b)(2)(B) *further defines severe need and the relevant factors which impact on the cost and complexity of delivering heath care and support services to people with HIV disease in the EMA.*

Supplemental awards are to be directed principally to those eligible areas with the most severe need based on documented factors that are comparable across EMAs. They should be targeted to those areas having the "greatest or expanding public health challenges in confronting the epidemic." The CARE Act Amendments of 2000 provided additional guidance on how HRSA/HAB is to consider the Severe Need factor in distributing Title I Supplemental grant funds among EMAs. In order to target funding to areas in greatest need of assistance, severity of need is given a greater weight in the scoring process. In determining severe need for the awarding of supplemental funds, it is the intent of Congress that the Secretary use national, quantitative incidence data to the greatest extent possible. HAB is engaged in studies with the Institute of Medicine and others to develop tools to be used in meeting this mandate by FY 2005.

Factors to be considered in the assessment of severe need for the FY 2004 application include:

- current prevalence of HIV disease;
- relative rates of increase in the number of cases of HIV disease;
- new or growing subpopulations of individuals with HIV disease;
- increasing need for HIV-related services, as determined by the needs assessment data;
- relative impact of Medicaid funds in supporting health care needs of individuals with HIV disease;
- relative rates of poverty and large numbers of uninsured individuals; and
- co-morbidities including high rates of STDs, Hepatitis, TB, substance use, severe mental illness, and other co-morbid factors that contribute to the cost of providing primary medical care and support services;

- Plan for responding to the CDC Initiative – Advancing HIV Prevention: New Strategies for a Changing Epidemic.

When describing severe need, applicants should document the use of multiple data sets, including HIV/AIDS epidemiological data, co-morbidity data, poverty and insurance-status data, and assessments of populations with special needs. Applications must demonstrate an understanding of both the quantity and nature of service needs in populations of special need. Applicants should also demonstrate that grantees and Planning Councils have taken measures to ensure that the needs assessment and planning processes adequately address the service needs of those in care, as well as those PLWH who are not in care. Narratives in this section should address meeting needs among all the following populations:

- PLWH from underserved communities that are disproportionately affected by HIV/AIDS;
- PLWH who know their HIV status but are not receiving primary medical care; and
- PLWH who are in the EMA system of care but whose needs are only being partially met.

HIV/AIDS Epidemiology

Supplemental funds will be targeted to those eligible areas where epidemiological data demonstrate that HIV prevalence rates are increasing and where there is a demonstrated disproportionate impact on vulnerable populations. The extent to which an EMA documents extensive unmet need for primary medical care in the EMA is also an important factor in determining the need for supplemental resources.

Table

Complete and submit Table 1: AIDS Incidence, AIDS Prevalence and HIV (not AIDS) Prevalence by Demographic Group and Exposure Category (see Section V.) HRSA/HAB will provide EMAs with CDC-generated HIV/AIDS prevalence and incidence data. HIV/AIDS prevalence and incidence data should be reported for the period through December 31, 2002.

Narrative

Using the information in Table 1 and/or Chapter 3 of the CDC/HRSA Integrated Guidelines for Developing Epidemiological Profiles, provide a narrative summary of the EMA's HIV/AIDS epidemic describing the elements listed below.

- Trends and changes in the EMA's HIV/AIDS cases, comparing:
  - the estimated number of people living with HIV
  - the number of people living with AIDS
  - the number of new AIDS cases reported within the past two years.

- Disproportionate impact of HIV/AIDS on certain populations in comparison to the impact on the general population.

- Estimated level of unmet need among PLWH in the EMA, using both the demographic categories and data provided in Table 1 and local service-utilization or CADR data.

- Populations of PLWH in the EMA that are underrepresented in the CARE Act-funded system of HIV/AIDS primary medical care. HRSA/HAB has asked all CARE Act Titles to encourage their funded service providers to make information on the number of persons in care available to Title I Planning Councils for this purpose.

Cost and Complexity of Providing Care

CARE Act funds are intended to supplement funding for local health care systems overburdened by the increasing cost of providing health care services. In addition to HIV/AIDS, public health care systems must also address a variety of co-morbidities that may increase the cost of delivering care to persons living with HIV/AIDS. Caring for large numbers of PLWH clients with multiple diagnoses also adds to the cost and complexity of care. In addition, most State Medicaid programs cover a broad range of PLWH health care benefits, though benefits and eligibility requirements vary from State to State.

Table

Using Table 6, provide quantitative data on each required co-morbidity as it has been measured or estimated for the EMA's general population. Provide quantitative data for insurance coverage and poverty as it has been measured or estimated for the EMA's general population. Data should include the percent and number of persons without insurance coverage (including those without Medicaid) and the percent and number of persons living at or below 300 percent of the 2002 Federal Poverty Level. Use the most recent data available and document data sources.

Narrative

Using the information contained in Table 6, describe how both service costs and the complexity of providing care to PLWH in the EMA are affected by co-morbidities, poverty and lack of insurance. Provide quantitative evidence on how these factors increase the costs of meeting health care needs.

Describe the extent to which the State Medicaid program covers PLWH health care costs in the EMA, including information on trends in enrollment and benefits. Discuss how this impacts the cost of providing health care in the EMA.

Assessment of Populations with Special Needs

The CARE Act requires Planning Councils to determine the needs of special populations and incorporate them into the comprehensive plan. Service gaps should be identified during the needs assessment process so that Title I funds can be directed to PLWH who may be disenfranchised from existing HIV/AIDS care services.

Table

Using Table 7, identify and describe the service needs of populations of PLWH in the EMA who are to be served in FY 2004. This table places special emphasis on identifying and planning for the service needs of special populations. Complete a summary table (7a) for the EMA and a separate table format (7b) for each of the following **six** populations:

1. Youth 13-24 years of age;
2. Injection drug users;
3. Substance users other than injection drug users;
4. Men of Color who have sex with men;
5. White/Anglo men who have sex with men; and
6. Women of child-bearing age (13 years of age and older).

In addition, applicants should complete additional Table 7b format(s) for other populations that have been significantly or disproportionately impacted by the epidemic and for each population identified as underserved. Whether or not a population has been impacted significantly should be evidenced by the data provided for underserved populations in Table 1; by the data provided from needs assessments; and by locally gathered data. Any other populations for whom service delivery is especially challenging should be included.

Unique Service Delivery Challenges

Narrative

Using the information from the narratives on Tables 1, 6 and 7 in this section, provide a clear and compelling description of the need for HIV/AIDS emergency grant funds in your EMA. Provide evidence of unique service delivery challenges in terms of both service costs and complexity of providing care (including for those who know their HIV status and are not in care.)

Definitions for key terms used to describe Severe Need.	
Severe Need:	The degree to which providing primary medical care to people with HIV disease in any given area is more complicated and costly than in other areas based on a combination of the adverse health and socioeconomic circumstances of the populations to be served.
Unmet Need for Health Services:	The need for HIV-related health services by individuals with HIV disease who are aware of their HIV status, but are not receiving primary health care.
Primary Medical Care for HIV	Medical evaluation and clinical care that is consistent with PHS Treatment Guidelines for the treatment of HIV/AIDS. Such care

Disease	must include access to antiretrovirals and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.
Health-Related Support Services:	Those non-medical support services that contribute to PLWH accessing and remaining in primary medical care.
In Care:	The receipt of primary medical care for HIV disease that is consistent with PHS Treatment Guidelines. Persons who are accessing support services but are not receiving primary medical care are not considered "in care."
Service Gaps:	All service needs of all PLWH, except for the primary care needs of those who know their status but are not in care.

IV.C.5 IMPACT OF TITLE I FUNDING: ACCESS TO CARE SERVICES AND FUNDING MECHANISMS …….5 POINTS

(Table 9 and narrative)

The purpose of this section is to provide a narrative summary describing the EMA's continuum of care during 2003, including access to care for those who know their status but are not presently in the system of HIV/AIDS primary medical care, access to primary medical care for special populations, and how service and funding mechanisms are coordinated.

LEGISLATIVE SUMMARY

Section 2602(b)(4)(E) *requires that the Planning Council establish methods for obtaining input on community needs and priorities (e.g., public meetings, focus groups, ad-hoc panels).*
Section 2602(b)(4)(B) *requires that Planning Councils develop a comprehensive plan for the delivery of HIV-related healthcare services.*
Section 2603(b)(1)(A) *requires grantees to report on the dissemination of emergency relief funds.*
Section 2602(c) *requires that grantees demonstrate that grants made in the preceding fiscal year were expended in accordance with the priorities of the Planning Council.*
Section 2603(b)(1)(D) *requires grantees to demonstrate the ability of the area to utilize supplemental resources in a manner that is immediately responsive and cost effective.*
Section 2602(b)(4)(C) *requires Planning Councils to assess the administrative mechanism in rapidly allocating funds and allows the Planning Council to assess the services offered in meeting identified need.*

Table

Complete Table 9, which shows other funding streams for HIV care and services in the EMA.

The EMA's Established Continuum of HIV/AIDS Care

Narrative

Briefly describe the EMA's continuum of care in FY 2003. Emphasize how the system of care is changing to address the service needs of newly affected and underserved populations — including those who know their HIV status but are not presently in the system of HIV/AIDS primary medical care.

Describe the EMA's System for Accessing Care

Narrative

Describe how the EMA's system of HIV/AIDS care is consistent with HRSA's goals of increasing access to services and decreasing HIV health disparities among affected subpopulations and historically underserved communities. The narrative should describe a comprehensive continuum of HIV/AIDS care accessible to all PLWH in the EMA, particularly to those who know their status but are not presently in the system of HIV/AIDS primary medical care. This description should include information on:

- Mechanisms within the EMA that enable newly infected, underserved and/or hard-to-reach individuals or communities to access and remain in primary medical care;
- The EMA's case management system and how case management services facilitate access to primary medical care and related HIV/AIDS services; and
- How MAI funds have been used to reduce disparities and to improve access to care and services for communities of color.

Coordination of Services and Funding Streams

Narrative

The CARE Act requires that services be provided in a manner that is coordinated, cost-effective, and ensures that Title I funds are the payer of last resort for HIV/AIDS services. Describe how Title I funds are coordinated with other CARE Act and non-CARE Act programs in the EMA, particularly those indicated in Table 9. In the description, provide the following information.

a. Coordination With Other CARE Act Programs

Discuss how services provided by CARE Act Title II, AIDS Drug Assistance Program (ADAP), III, IV, Special Projects of National Significance (SPNS), AIDS Education and Training Centers (AETCs), and Dental Reimbursement programs in the EMA are taken into consideration during the Title I priority setting and allocation processes. Explain how programs receiving these funds are coordinated to maximize the number and accessibility of services available. Describe the EMA's local pharmacy program, 340B program, voucher program, ADAP co-pay, etc if such programs exist in the EMA. Include in this discussion the reason that your EMA has elected to establish its own HIV/AIDS related pharmacy program in lieu of or in addition to supporting your respective State ADAP activities. Please provide evidence that the EMA pharmacy program is participating in the 340B initiative or provide a corrective action plan that will result in 340B participation.

b. Coordination With Other State and Federal Resources

Discuss how Title I planning includes efforts to expand the availability of services, reduce duplication of services, bring people into care who know their status but are not presently in the system of HIV/AIDS primary medical care, and ensure that CARE Act funds are the payer of last resort. In particular, reference ways in which services funded by the sources below are taken into consideration in planning for the continuum of HIV care and during the priority setting and allocation processes.

- CDC Prevention Program
- State Medicaid Program
- State Children's Health Insurance Program (SCHIP)
- Veterans Affairs Programs, especially VA HIV/AIDS Clinics

- The Department of Housing and Urban Development's Housing Opportunities for Persons With HIV/AIDS Programs (HOPWA)
- Services for Women and Children, [i.e., Special Supplemental Food Program for Women, Infants, and Children (WIC) Program and Substance Abuse Treatment Programs for Pregnant Women]
- Other State and Local Social Service Programs (i.e. General Assistance, Vocational Rehabilitation)
- Local and Federal funds for substance abuse and mental health treatment services

IV.C.6 PLANNING COUNCIL MANDATED ROLES/RESPONSIBILITIES: PRIORITY SETTING AND COMPREHENSIVE PLANNING.....8 POINTS
(Tables 8, 11 and narratives)

The purpose of this section is to describe how the Planning Council carried out its mandated roles and responsibilities in FY 2003. Responses should indicate how the size and demographics of the population of individuals with HIV was determined; how the needs of the population were determined; and how FY 2004 priorities for the allocation of funds were established. Explain how the Planning Council responded to requirements related to comprehensive planning and its involvement in the development of the Statewide Coordinated Statement of Need. Points will be awarded based on the submission of completed tables and a narrative that includes information in response to the specific areas outlined below.

LEGISLATIVE SUMMARY

Section 2602(b)(4) *defines the duties of the Planning Council, including determining the size and demographics of the population of individuals with HIV disease, determining the needs of such population, establishing priorities for the allocation of funds within the EMA, developing a comprehensive plan, assessing the efficiency of the administrative mechanism in rapidly allocating funds, assessing the services offered in meeting identified needs, and establishing methods for obtaining input on community needs and priorities.*

Section 2602(b)(4)(A) *requires that the Planning Council determine the size and demographics of the population of individuals with HIV disease, establish priorities for the allocation of funds within the EMA, including how best to meet those priorities.*

Section 2602(b)(4(B)) *requires that the Planning Council determine the needs of this population with particular attention to (i) individuals with HIV disease who know their HIV status and are not receiving primary medical care, and to (ii) disparities in access and services among affected subpopulations and historically underserved communities.*

Section 2602(b)(4(C)) *requires that the Planning Council establish priorities for the allocation of funds within the EMA, including how best to meet such a priority and additional factors that the grantee should consider in allocating funds under a grant based on (i) size and demographics of the population of individuals with HIV disease; (ii) demonstrated (or probable) cost effectiveness and outcome effectiveness of proposed strategies and interventions; (iii) priorities of the communities with HIV disease for whom the services are intended; (iv) coordination in the provision of services to such individuals with programs for HIV prevention and for the prevention and treatment of substance abuse, including programs that provide comprehensive treatment of such abuse; (v) availability of other governmental and nongovernmental resources…; (vi) capacity development needs resulting from disparities in the availability of HIV-related services in historically under-served communities.*

Section 2602(b)(4)(D) *requires Planning Councils to develop a comprehensive plan for the organization and delivery of health and support services described in section 2604.*

Sec.2602. (4) *"The Planning Council established or designated under paragraph (1) shall assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area and, at the discretion of the Planning Council, assess the effectiveness, either directly or through contractual arrangements, of the services offered in meeting the identified needs.*

Section 2603(b)(1)(E) *requires grantees to demonstrate that resources will be allocated at no less than the percentage constituted by the ratio of the population of infants, children, youth, and women with AIDS to the general population with AIDS.*

Section 2603 (b) (1) (G) *requires that grantees demonstrate the manner in which proposed services are compatible with the local needs assessment and the Statewide Coordinated Statement of Need.*

Section 2605 (a) (8) *indicates that to be eligible to receive a grant under Section 2601, an eligible area shall prepare and submit to the Secretary an application …including assurances that … the applicant has participated in, or will agree to participate in, the Statewide Coordinated Statement of Need process.*

Comprehensive Plan

Planning is central to the CARE Act's focus on local decision-making in developing HIV/AIDS care systems. Each grant year, Planning Councils establish service and resource allocation priorities and implementation plans to address them. Comprehensive HIV services planning goes beyond this annual process and provides a road map for developing a system of care over time. This is accomplished by a review of needs assessment data, such as the needs of persons living with HIV disease that are both in and out of care, existing resources to meet

those needs, and barriers to care. Additional information to review includes evaluation data (including data on cost-effectiveness and outcome effectiveness of services) and aggregate (per service category) contract monitoring data.

The purpose of comprehensive HIV services planning is to help Planning Council members develop a detailed picture of the current HIV/AIDS epidemic in the EMA, identify possible future trends, and guide decisions about HIV-related services and resources in the EMA. Information from comprehensive planning is used to determine long-term goals, objectives, and strategies for delivering services. The plan also reflects the community's vision and values about how best to deliver HIV/AIDS care, particularly in light of limited resources

Narrative

Provide a narrative discussion addressing the following:

- The linkages between the EMA's latest needs assessment, the comprehensive plan, service priorities, and the FY 2004 implementation plan, including reference to specific goals;

Data/Information Used for Priority Setting and Allocation of Funds

Tables

Complete the following tables:

Table 8: Data/Information Used for Priority Setting and Allocation of Funds.

Table 11: Summary of Priority Services to Be Funded in FY2004. Summarize the results of the priority setting and resource allocation processes. Include a copy of the FY 2003 final allocation table or integrate information with this table that compares priorities from FY 2003 to those of FY 2004. List in descending order the FY 2004 service, geographic or population-based priorities determined by the Planning Council.

Also, as an attachment to Table 11, include language developed by the Planning Council regarding how each priority should be met.

Narrative

Planning Councils are responsible for setting service priorities, determining how best to meet these priorities, and allocating resources for them. The needs assessment and comprehensive plan should be linked with the priority setting process to help the Planning Council make resource allocations based on need.

Describe the priority setting and allocation processes including information on how the process was reviewed, how consumers' needs and preferences across diverse populations were

addressed. Also, describe how the needs of those not in care and those from historically underserved populations were incorporated. Include the following elements.

- How the data listed in Table 8 were used in the priority setting and allocation processes to increase access to services and to reduce disparities in access to the EMA's continuum of HIV care.

- How current data and information were used to establish priorities. Explain how changes and trends in HIV/AIDS epidemiology data were used to set priorities. In addition, explain how each data/information item checked in Table 8 was used to determine the amount of funds allocated for services.

- Examples of how the Planning Council used data to make changes, in the percent or amount of allocated to certain priorities. Discuss the Planning Council's use of quantitative data in determining the unmet HIV/AIDS service needs of members of those not in care.

- The involvement of PLWH in the priority setting and allocation processes. Specifically, describe how the priorities of HIV-infected communities, for whom CARE Act services are intended, are considered in the process of setting priorities and allocating funds.

- Efforts by the Planning Council to address the needs of, and reduce the barriers for, the populations identified in Table 7.

- Contingency planning efforts in the Planning Council to monitor for, and to respond to, increased need for primary medical care due to potential increases in the number of HIV-positive individuals identified through the new CDC prevention initiative.

Compatibility with Statewide Coordinated Statement of Need (SCSN)

Narrative

Describe how the proposed use of FY 2004 Title I funds is consistent with the most recent SCSN.

Planning Council Assessment of the Administrative Mechanism

Narrative

Briefly describe the process used by the Planning Council to assess the efficiency of the administrative mechanism and include a short summary of the report. Additionally, include with your application the most recent copy of the assessment tool and the final Planning Council report.

IV.C.7 Update on Assuring Quality Management Programs and Outcomes Evaluation Activities ……5 Points
(Narrative only)

The purpose of this section is to allow applicants to describe their progress in implementing quality management programs, the activities used to assess quality, and the services for which health status outcomes have been developed and implemented.

LEGISLATIVE SUMMARY

Section 2604(C) *requires that the Chief Elected Official of an eligible metropolitan area provide for the establishment of a quality management program to assess the extent to which HIV health services provided to patients are consistent with the most recent Public Health Service guidelines for the treatment of HIV disease and related opportunistic infections, and to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of health services.*

By establishing quality management programs and quality service indicators, Title I programs can ensure that eligible persons living with HIV disease have access to quality treatment and health care services. Quality management programs, as set forth in the CARE Act should accomplish three goals:

- Assist direct service medical providers in assuring that funded services adhere to established HIV clinical practice standards and PHS Treatment Guidelines;
- Ensure that strategies for improvements in quality medical care include vital health-related support services in achieving appropriate access and adherence to HIV medical care; and
- Ensure that available demographic, clinical and primary medical care utilization information is used to monitor HIV-related illnesses and trends in the local epidemic.

The ultimate goal of quality management programs is to improve client health. This is accomplished through the establishment and monitoring of standards for clinical services and the supportive services that link clients with primary medical care. At a minimum, grantees must be able to demonstrate that Title I funded primary medical care and support services are consistent with PHS Treatment Guidelines for adults, adolescents, pediatrics, perinatal exposure, non-occupational exposure, primary medical care worker exposure, opportunistic infections and TB. Current treatment guidelines are available at www.aidsinfo.gov .

Grantees must ensure that subcontractors have quality management programs in place. Through quality management efforts, service providers should be able to identify problems in service delivery that impact health status outcomes at the client and system levels. Evidence of quality management activities should include: requirements in contract language with service providers, site-visit protocols and other monitoring efforts performed by the grantee. Periodically, HAB/DSS initiates or collaborates with other government agencies, universities, or national organizations to evaluate the outcomes of Title I Programs. Grantees are expected to participate in HRSA-sponsored evaluation studies.

Narrative

Provide a description of current and planned activities that have been, or will be, implemented in the EMA to assure the quality of services. Where both the grantee and the Planning Council fund quality management, describe how the activities are coordinated. The narrative must address the following:

Quality Management Activities During the FY 2003 Grant Year

- Describe what activities or quality programs have been put in place.

- Describe what service categories have quality service indicators developed. List the service indicators associated with each service category. Examples may include:

  a. 75 percent of all clients will be on combination therapy according to PHS guidelines.
  b. 75 percent of all clients will have CD4 counts and viral loads monitored consistent with PHS guidelines.
  c. 80 percent of all clients will realize a decrease in viral load.
  d. 80 percent of all clients will maintain or have an increased CD4 count.
  e. 75 percent of all clients will be assessed for medication adherence and educated accordingly.

- Describe what data collection has been performed and what the results show.

- In cases where both the grantee and the Planning Council fund quality activities, describe how activities are coordinated. How do the activities differ from grantee to Planning Council?

Use of Costs in Evaluating Services

As funding decreases, it is imperative for grantees and Planning Councils to consider the costs of services in funding allocation decisions.

- Discuss efforts by the EMA to estimate the cost of services either as unit cost or cost per client.

- Discuss how cost data is used by the Planning Council in funding allocation decisions.

Progress in Developing Outcome-Based Service Evaluation

DSS expects that EMAs have methods in place to measure client-level outcomes for primary medical care and case management services. Provide the following information:

- What client-level outcomes been developed and implemented in the EMA? List the outcomes that correspond to each service category.

- What service categories does the EMA plan to focus on in FY 2004 for either development of outcomes or revision and refinement of existing outcomes?

Definition of Key Terms Used to Describe Outcomes

Client-level Outcomes:	Benefits or results for individual clients and include psychosocial measures (improved level of functioning), biologic measures (stabilization or increased CD4 counts) or morbidity measures (decreased number of opportunistic infections)
Outcome Indicators:	Observable, measurable data sets (such as the number of referrals completed by clients or non-injury related emergency room visits over time) used to track a program's success in reaching desired outcomes

IV.C.8 PLAN FOR FY 2004……..8 POINTS
(Table 10 and narrative)

The purpose of this section is to present the FY 2004 HIV/AIDS service plan, with specific attention to ensuring increased access to a continuum of HIV/AIDS care. The plan should clearly show how the EMA will reduce or eliminate service and health outcome disparities among populations with specific needs as identified in Table 7. The plan must include objectives to address the unmet needs of those persons in care as well as those who know their HIV status but are not in HIV/AIDS primary medical care. The FY 2004 Plan also must clearly identify those initiatives funded through the MAI.

LEGISLATIVE SUMMARY

Section 2603(b)(1)(A) *requires grantees to report on the plan for utilization of CARE Act funds.*
Section 2605(b) *requires that the application for funds include information concerning the individuals to be served with those funds*
Section 2604(b)(3) *Priority for Women, Infants, Children and Youth. "For the purpose of providing and supporting services to infants, children, youth and women with HIV disease, including treatment measures to prevent the perinatal transmission of HIV, the chief elected official of the eligible area in accordance with Planning Council established priorities, shall use, of the grants made available for the area under section 2601(a) for a fiscal year, not less than the percentage constituted by the ratio of the population in such area of infants, children, youth, and women with acquired immune deficiency syndrome to the general population in such area of individuals with such syndrome."*

Table 10: Quantified, Time-Limited Service Goals and Objectives for FY 2004

For each of the priorities listed in Table 11, the applicant must develop one or more service goals with time-limited and measurable program objectives in Table 10. These service goals and objectives comprise the FY 2004 Implementation Plan. For each objective, define the service unit, the number of persons to be served, the units of service to be delivered, and the estimated cost of meeting the objective. Include and clearly label MAI objectives under each priority funded through that program.

FY 2004 Plan: Providing Access to HIV Care and Reducing Disparities

Narrative

Discuss how the EMA's FY 2004 Implementation Plan will ensure access to HIV/AIDS primary medical care and support services and reduce disparities in access to care across the EMA. The narrative should highlight goals and objectives in Table 10 that focus on services to PLWH in communities where HIV (not AIDS) prevalence is increasing. Discuss those initiatives funded by the MAI where appropriate. Indicate how your FY 2004 Implementation Plan will respond to changes in the epidemic in the EMA.

TABLE 10 SHOULD:

- Identify and describe objectives to provide access to the HIV continuum of care for

communities where HIV (not AIDS) prevalence is increasing and for persons who know their HIV status but are not in HIV/AIDS primary medical care.

- Identify and describe objectives that address the needs of special populations identified in Table 7 and how individual (percentage) allocations were determined.

- Identify and describe objectives to ensure parity of HIV services throughout the EMA. Parity of services should be addressed in terms of geographic location of services, compatibility of quality, comprehensiveness of services, and cultural appropriateness.

- Identify and describe objectives to ensure that PLWH remain engaged in HIV/AIDS primary medical care and adhere to HIV treatments.

- Identify and describe objectives to ensure that resource allocations for services to women, infants, children, and youth are in proportion to the percentage of the EMA's AIDS cases represented by each population.

IV.C.9 PROPORTIONAL RESOURCE ALLOCATION FOR WOMEN, INFANTS, CHILDREN AND YOUTH …….5 Points

In this section, applicants are asked to describe efforts to ensure that services are provided to women, infants, children and youth (WICY) in proportion to their representation in the local HIV epidemic. Points will be awarded based on submission of completed narratives.

LEGISLATIVE SUMMARY

Section 2604(b)(3) *Priority for Women, Infants, Children and Youth. "For the purpose of providing and supporting services to infants, children, youth and women with HIV disease, including treatment measures to prevent the perinatal transmission of HIV, the chief elected official of the eligible area in accordance with Planning Council established priorities, shall use, of the grants made available for the area under section 2601(a) for a fiscal year, not less than the percentage constituted by the ratio of the population in such area of infants, children, youth, and women with acquired immune deficiency syndrome to the general population in such area of individuals with such syndrome."*

Section 2604 (B) Waiver – *With respect to the population involved, the Secretary may provide to the chief elected official of an eligible area a waiver of the requirement of subparagraph (A), if the official demonstrates to the satisfaction of the Secretary that the population is receiving HIV-related health services through the State Medicaid program, the State Children's Health Insurance Program or other Federal or State programs.*

The CARE Act Amendments of 2000 require grantees to demonstrate that resources for WICY with HIV/AIDS are proportionate to their representation within the overall HIV/AIDS population. The intent of Congress is to assure the availability of, and access to, primary medical care and health-related supportive services for these four specific populations. Please refer to DSS May 27, 2002 letter for specific instructions.

Planning Council Prioritization

Services directed to WICY must be funded in accordance with the service priorities established by the Title I Planning Council.

Narrative

Describe Planning Council efforts in meeting the mandated WICY requirements during their priority, allocation, and reallocation processes.

Coordination

Narrative

Describe how Title I funds are coordinated with other CARE Act and non-CARE Act programs to reduce duplication and increase access to care for WICY.

Progress in Implementing Tracking Requirements

Grantees are required to provide HIV/AIDS health and support services for WICY based on the percentage that they represent in the total population of people living with HIV disease. This requirement is subject to audit. Therefore, grantees must utilize a consistent system and method for documenting expenditures separately for each of the four population groups.

Narrative

Describe grantee accomplishments and challenges regarding the separate tracking of expenditures for WICY, consistent with HAB/DSS guidelines of May 2002. If the EMA has applied for a retrospective or prospective waiver, please include that information.

Plan for FY 2004

Narrative

Identify and describe objectives in Table 10 that reflect Planning Council established priorities and ensure compliance with the resource allocation requirement for WICY.

SECTION V:

FY 2004 APPLICATION

TABLES

Applicants that need assistance with preparing responses to any of the tables should call their DSS Project Officer at the address and telephone number below:

Health Resources and Services Administration
HIV/AIDS Bureau, Division of Service Systems
5600 Fishers Lane, Room 7A-55
Parklawn Building
Rockville, MD 20857
Tel: (301) 443-9086

Applicants can download copies of all tables from the HAB website www.hab.hrsa.gov

Tables should be included with the application as Attachment 1.

TABLE 1: AIDS INCIDENCE, AIDS PREVALENCE AND HIV (NOT AIDS) PREVALENCE BY DEMOGRAPHIC GROUP AND EXPOSURE CATEGORY

INSTRUCTIONS

Complete Table 1 using AIDS incidence, AIDS prevalence and HIV (not AIDS) prevalence data by demographic group and exposure category. HAB/DSS has provided a printout of AIDS incidence and prevalence data in Appendix 4 of the guidance. Please see Appendix 4 for additional information on the availability of HIV data. All data should be reported through December 31, 2002.

NOTE:

- The categories under adult/adolescents and pediatric sections called "Other/hemophilia/blood transfusion" should include infection through hemophilia, coagulation disorder, receipt of blood transfusion, blood components or tissues, and other.

- Please note cases coded as multi-race in a separate category as indicated under race ethnicity section

TABLE 1: AIDS INCIDENCE, AIDS PREVALENCE AND HIV (NOT AIDS) PREVALENCE
BY DEMOGRAPHIC GROUP AND EXPOSURE CATEGORY
STATE/ELIGIBLE METROPOLITAN AREA (EMA) _____

Demographic Group/ Exposure Category	AIDS INCIDENCE: 01/01/01 TO 12/31/02 *AIDS incidence is defined as the number of new AIDS cases diagnosed during the period specified.*		AIDS PREVALENCE AS OF 12/31/02 *AIDS Prevalence is defined as the number of people living with AIDS as of the date specified.*		HIV (NOT AIDS) PREVALENCE AS OF 12/31/02 *HIV Prevalence is defined as the estimated number of diagnosed people living with HIV (not AIDS) as of the date specified.*	
Race/Ethnicity	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**
White, not Hispanic						
Black, not Hispanic						
Hispanic						
Asian/Pacific Islander						
American Indian/Alaska Native						
Multi- Race						
Unknown						
Gender	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
Male						
Female						
Total						
Age at Diagnosis (Years)	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
<13 years						
13 - 19 years						
20 - 44 years						
45+ years						
Total						

TABLE 1: AIDS INCIDENCE, AIDS PREVALENCE AND HIV (NOT AIDS) PREVALENCE (CONT'D)

Demographic Group/ Exposure Category	**AIDS INCIDENCE: 01/01/01 TO 12/31/02** *AIDS incidence is defined as the number of new AIDS cases diagnosed during the period specified.*		**AIDS PREVALENCE AS OF 12/31/02** *AIDS Prevalence is defined as the number of people living with AIDS as of the date specified.*		**HIV (NOT AIDS) PREVALENCE AS OF 12/31/02** *HIV Prevalence is defined as the estimated number of diagnosed people living with HIV (not AIDS) as of the date specified.*	
Adult/Adolescent AIDS Exposure Category	***#***	***% of Total***	***#***	***% of Total***	***#***	***% of Total***
Men who have sex with men						
Injection drug users						
Men who have sex with men and inject drugs						
Heterosexuals						
Other/Hemophilia/blood transfusion						
Risk not reported or identified						
Total						
Pediatric AIDS Exposure Categories	***#***	***% of Total***	***#***	***% of Total***	***#***	***% of Total***
Mother with/at risk for HIV infection						
Other/Hemophilia/blood transfusion						
Risk not reported or identified						
Total						

Please Complete: Does your State have HIV reporting? (Check one.) Yes ☐ No ☐

TABLE 2: ROSTER OF THE FY 2004 TITLE I PLANNING COUNCIL MEMBERS

INSTRUCTIONS

The CARE Act requires that Title I HIV Health Services Planning Councils reflect in their composition the demographics of the epidemic, with particular consideration given to disproportionately affected and historically underserved groups and subpopulations. The 2000 CARE Act Amendments increased the participation of non-aligned consumers to 33 percent, and required that this membership also reflect the demographics of individuals living with HIV/AIDS. In addition, Planning Councils are required to include representatives of each of the following membership categories:

1. Health care providers, including Federally qualified health centers;
2. Community-based organizations serving affected populations and AIDS-service organizations;
3. Social service providers, including housing and homeless services providers;
4. Mental health providers;
5. Substance abuse providers;
6. Local public health agencies;
7. Hospital planning agencies or healthcare planning agencies;
8. Affected communities, including individuals with HIV disease or AIDS, and historically underserved groups and subpopulations;
9. Non-elected community leaders;
10. State Medicaid agency;
11. State agency administering the Title II program;
12. Title III CARE Act grantees;
13. Title IV CARE Act grantees under section 2671of the PHS Act that provide coordinated services and access to HIV-related medical research for women, infants, children, or youth, or, if none exists, representatives of organizations operating in the EMA that have a history of serving children, youth, and families living with HIV;
14. Grantees under other Federal HIV programs, including HIV prevention programs; and
15. Formerly incarcerated PLWH or their representatives.

Complete Tables 2, 3, and 4 based on the membership of the Planning Council as of September 1, 2003.

Table 2 is comprised of a roster of Planning Council members. In addition to answering questions 1 through 5, list each Planning Council member's name, the category she or he represents (1-15 above), and the beginning and end dates of appointment. While an individual member may qualify to fill more than one legislatively mandated category, for the purposes of completing this chart, members may only represent one category. Alternates may be listed and identified on the roster, but they should not be included in responding to questions 1-5

.

TABLE 2: ROSTER OF THE FY 2004 TITLE I PLANNING COUNCIL MEMBERS

EMA: _____

1. What is the total authorized/prescribed number of Planning Council members according to council by-laws? _____
2. How many individuals were officially serving as Planning Council members on 09/01/03? _____
3. Of the number of members identified in #2, what percentage are PLWH? _____
4. Of the number of members identified in #2, what percentage are non-aligned consumers? _____*
5. Do at least two members of the Planning Council publicly disclose their HIV status?
   Yes □ No □

*The Amended Ryan White CARE Act of 2000 requires that non-aligned consumers must constitute a minimum of 33 percent of the Planning Council voting membership and that at least two members are persons who publicly disclose their HIV status.

REPRESENTATIVE: Name: Title: Affiliation:	Category of Representation: *(Within 15 designated categories)*	DATES OF APPOINTMENT: *(Month and year, beginning and ending dates)*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

(Add additional pages as needed)

TABLE 3: MATRIX FOR PLANNING COUNCIL MEMBERSHIP CATEGORIES

INSTRUCTIONS

Table 3 is a chart of the legislatively mandated membership categories that must be represented on the Planning Council. Table 3 also is used to determine the extent to which the Planning Council membership is reflective of the epidemic in the EMA.

Representation of Mandated Categories

For each mandated category, enter the number of Planning Council members by race/ethnicity and gender. Each Planning Council member should be included on this chart only once. While individual members may fill more than one legislatively mandated category, for the purposes of completing this chart they may represent only one category. EMAs may include as many representatives for each membership category as locally determined to be appropriate in order to achieve adequate community representation. However, at a minimum, Planning Councils must include at least one member to SEPARATELY represent each of the 15 mandated categories. In the second TOTAL row at the bottom of the table, enter the number of non-aligned persons living with HIV/AIDS by race/ethnicity and gender. Non-aligned is defined as having no financial or governing interest in Title I funded agencies.

[Please note: Three exceptions exist to the rule on separate representation. For example, one person may represent a substance abuse provider and a mental health provider if the agency represented by the member provides both types of services and the person is familiar with both programs. Similarly, a single Planning Council member may represent both the CARE Act Title II grantee and the State Medicaid Agency, if that person is in a position of responsibility for both programs. Finally, one person may represent a combination of CARE Act Part F grantees — those funded under the Special Projects of National Significance (SPNS) program, the AIDS Education and Training Centers (AETC) program, and the Dental Reimbursement Program — and HUD Housing HOPWA grantees, in instances where the Planning Council member represents an agency that receives grants from each program (e.g., a provider that receives both HOPWA and SPNS funding).

The category "Other Federal HIV Programs, including HIV Prevention programs" is to include, at a minimum, grantees of: CARE Act SPNS, AETC, and Dental Reimbursement Programs, and HOPWA. Planning Councils must include a representative for each program providing services within the EMA. Local grantees of, or participants in, other Federal, categorical HIV and STD programs (e.g., CDC Prevention grants, National Institutes of Health (NIH) Community Programs for Comprehensive Research on AIDS, HIV specific Substance Abuse and Mental Health Services Administration (SAMHSA) or National Institute of Mental Health (NIMH) programs), should be considered for representation on the Planning Council, but are not specifically required. The totals at the bottom of Table 3 should add to the total number of Planning Council members.

TABLE 3: MATRIX FOR PLANNING COUNCIL MEMBERSHIP CATEGORIES

EMA:	RACE/ETHNICITY, AND GENDER									
Mandated Categories of Representation and Reflectiveness of the Epidemic in the EMA	**White/not Hispanic**		**Black/not Hispanic**		**Hispanic**		**Asian/Pacific Islander**		**Am. Indian/Alaska Native**	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
1. Healthcare providers, including Federally Qualified Health Centers										
2. CBOs serving affected populations/AIDS Service Organizations (ASOs)										
3. Social Service Providers, including housing and homeless services providers										
4. Mental Health										
5. Substance Abuse Providers										
6. Local Public Health Agencies										
7. Hospital planning agencies or other healthcare planning agencies										
8. Affected Communities, including PLWH and historically underserved subpopulations										
9. Non-elected community leaders										
10. State Medicaid Agency										
11. State Title II Agency										
12. Title III										
13. Title IV, or if none present, representatives of organizations addressing the needs of children, youth, and families with HIV										
14. Other Federal HIV Programs, including HIV Prevention programs										
15. Representatives of/or formerly-incarcerated PLWH										
TOTAL										
TOTAL Non-aligned PLWH										

TABLE 4: REFLECTIVENESS OF NON-ALIGNED CONSUMERS AND PLANNING COUNCIL MEMBERS BY DEMOGRAPHIC GROUP

INSTRUCTIONS

Table 4 is a demographic worksheet to aid you in determining the reflectiveness of Planning Council membership , including PLWH representation . When completing the table please keep the following in mind.

1. To determine HIV Disease Prevalence for purposes of reflectiveness, add together AIDS Prevalence and HIV Prevalence (not AIDS).

2. In the rows following the race/ethnicity, gender and age category, record the total number of members in the left cell and the percentage on the right cell.

Under the column titled "Members of the Planning Council," record the gender and current age of members.

4. Age is not required under "Living with HIV Disease" and "Non-Aligned Consumers"

TABLE 4: REFLECTIVENESS OF NON-ALIGNED CONSUMERS AND PLANNING COUNCIL MEMBERS BY DEMOGRAPHIC GROUP

EMA: _____

Total Members as of September 1, 2003 _____
Total Non-aligned Consumers: _____
Percent Non-aligned Consumers _____

NOTE: Modes of transmission should be considered when constructing a reflective PLWH membership, but are not required.

	Living with HIV Disease (inc. AIDS) in the EMA through 12/31/01		**Members of the Planning Council**		**Non- Aligned Consumers on Planning Council**	
Race/Ethnicity	Number	Percentage	Number	Percentage	Number	Percentage
White, not Hispanic						
Black, not Hispanic						
Hispanic						
Asian/Pacific Islander						
American Indian/Alaska Native						
Multi-Race						
Not Specified						
Total						
Gender	Number	Percentage	Number	Percentage	Number	Percentage
Male						
Female						
Total						
Age (Years)			Number	Percentage		
<13 years						
13-19 years						
20-44 years						
45+						
Total						

TABLE 5: GRANTEE MONITORING OF CONTRACTORS

INSTRUCTIONS

1. Using Table 5, provide information on monitoring of contractors.

Using Table 5, complete the relevant columns for each question by providing the number, the number and percentage, or indicating yes or no in the appropriate column. Use information from the current contract year.

TABLE 5: GRANTEE MONITORING OF CONTRACTORS

EMA_____
Total Number of Subcontractors Monitored by Grantee _____

All responses should relate to current contract year activity	**Number**	**Percent**	**Yes**	**No**
Fiscal Monitoring				
How many current providers have received a fiscal site visit since March 1, 2003?				
How many providers will have received a fiscal site visit by February 28, 2004?				
How many times per year are fiscal reports required from each provider?				
Have corrective actions been taken as the result of a fiscal related concern?				
Have any contracts been terminated or modified as the result of a fiscal concern?				
Does the administrative agent retain copies of all fiscal reports?				
Program Monitoring				
How many providers have received programmatic site visits since March 1, 2003?				
How many providers will have received programmatic site visits by February 28, 2004?				
How many times per year are programmatic progress reports required from each provider?				
How many corrective actions have been taken as the result of a programmatic concern?				
How many (sub) contracts were terminated or modified as the result of a programmatic concern?				
Has technical assistance been provided as the result of a programmatic concern?				
Does the administrative agent retain a copy of all programmatic site visit reports?				
Third Party Reimbursement				
Has the grantee received training on third party reimbursement?				
Does the grantee ensure contractors receive third party reimbursement training?				
Does the grantee provide TA to contractors on third party reimbursement?				

All responses should relate to current contract year activity	**Number**	**Percent**	**Yes**	**No**
A-133 Audits				
How often are subcontractors required to submit OMB Circular A-133 fiscal audits?				
How many subcontractors submitted results of fiscal audits?				
How many agencies had significant findings on their audits?				
How many agencies had corrective action plans put in place as a result of a fiscal audit?				
Assessment of the Administrative Mechanism				
Were corrective actions taken in response to the Planning Council's most recent evaluation of the administrative mechanism? (if no, explain in narrative)				

TABLE 6: CO-MORBIDITY, POVERTY, INSURANCE STATUS AND MEDICAID COVERAGE

INSTRUCTIONS

2. Using Table 6, provide quantitative data on each co-morbidity for the EMA's general population. Document data sources using the most recently available data.

3. Using Table 6, provide quantitative data for the EMA's general population including percent/number without insurance coverage, percent/number without Medicaid and the percent/number below 300 percent of the 2002 Federal Poverty Guidelines. Document data sources, using the most recently available data.

TABLE 6: CO-MORBIDITY, POVERTY, INSURANCE STATUS AND MEDICAID COVERAGE

EMA:			
CO-MORBIDITIES, QUANTITATIVE DATA			
Co-morbidity	**Prevalence within the general population within the EMA**		**Data Source and Date**
Tuberculosis			
Syphilis			
Gonorrhea			
Intravenous Drug Users			
Other Substance Abuse *(i.e. alcohol, Methamphetamine, cocaine, inhalants)* Please specify_____			
Homelessness			
Severe Chronic Mental Illness			
Other co-morbidities (optional)			
INSURANCE, POVERTY STATUS AND MEDICAID COVERAGE			
INSURANCE STATUS*	Number	Percentage	
POVERTY**	Number	Percentage	
MEDICAID COVERAGE	Number	Percentage	

* Persons in EMA without insurance coverage, including those without Medicaid

** Persons in EMA below 300 percent of the Federal Poverty Level

TABLE 7: ASSESSMENT OF POPULATIONS WITH SPECIAL NEEDS

INSTRUCTIONS

On Table 7a, provide the required information for each of the six demographic groups in the EMA.

- Youth (13 - 24 years old);
- Injecting Drug Users (IDUs);
- Other Substance Users;
- Men of color who have sex with men;
- White/Anglo men who have sex with men; and
- Women of child bearing age (13 years old and older)

Additional categories (which may or may not be mutually exclusive) are to be determined by each EMA. Examples of such populations might include homeless, immigrants (e.g. undocumented, documented, newly arrived), residents of a specific geographic location who are particularly impacted by the epidemic, or any other identified population, sub-population, or group, that an EMA feels needs more qualitative discussion.

A separate Table 7b must be complete for each of the six populations identified above, as well as any additional populations with special needs identified in the EMA. All questions should be answered for all populations (i.e., those required by the application and those identified by the EMA).

TABLE 7a: ASSESSMENTS OF POPULATIONS WITH SPECIAL NEEDS (SUMMARY SHEET)

EMA:				
SUMMARY OF POPULATION ESTIMATES				
Demographic Group/Exposure Category	Estimated number of persons in this population group in the EMA (regardless of HIV status)	Estimated number of persons in this population group living with AIDS in the EMA	Estimated HIV (not AIDS) prevalence rate in the EMA for the population	Estimated number of persons in this population with HIV infection (including AIDS) in the EMA
Youth, 13-24 years				
Injecting drug users				
Other substance users				
Men of color who have sex with men				
White/Anglo men who have sex with men				
Women of child- bearing age (13 yrs and older)				
Other population groups _____ (please specify)				

TABLE 7.b. ASSESSMENT OF POPULATIONS WITH SPECIAL NEEDS (POPULATION DESCRIPTION FORMATS)

EMA:
Population Group:
POPULATION DESCRIPTION
1. Briefly describe this population group, including geographic distribution, income level, any language/cultural barriers, and other relevant characteristics.
2. Describe the HIV infection and risk trends in this population.
3. Discuss how the special needs of this population were determined in the Need Assessment and how the Planning Council addressed these specific needs in their priority setting and allocation decisions.
4. Describe the HIV/AIDS service needs of individuals in this population who know their status and who are in HIV/AIDS primary medical care.
5. Describe the extent to which members of this population group <u>are not</u> in a system of HIV/AIDS primary care and the barriers to care for those individuals.

TABLE 8: DATA/INFORMATION USED FOR PRIORITY SETTING AND ALLOCATION OF FUNDS

INSTRUCTIONS

Check each data or information element used in the FY 2004 priority setting and allocation processes.

1. Provide the date this information was last updated.

2. Identify who used the information (e.g., the full Planning Council or Priorities/Allocations Committees) and for what purpose, (i.e., priority setting, allocation of funds, or both).

TABLE 8: DATA/INFORMATION USED FOR PRIORITY SETTING AND ALLOCATION OF FUNDS
EMA:_____

Check if used	Data/Information Used for Priority Setting and Allocation of Funds	Current as of *(Mo/Yr)*	Used by *(e.g. full Planning Council, Priorities/ Allocation Committees)*
	Epidemiological Data		
	Trends/changes in HIV Incidence and/or Prevalence		
	Trends/changes in AIDS Incidence and/or Prevalence		
	Changes in the demographics of the EMA's HIV/AIDS cases in relation to the total population as a measure of disproportionate impact on specific populations		
	Information regarding populations with special needs as documented in Table 6, includin barriers to care and other access issues		
	Quantitative data regarding persons living in the EMA who know they have HIV but are not in HIV/AIDS primary medical care		
	Capacity Development Needs by Service Category		
	Outcome Evaluation Data (e.g., effects on clients receiving specific services)		
	Client-level Health-Status Outcomes – Primary Medical Care		
	Other Health-Status Outcomes (Describe in narrative)		
	Outcomes for other Primary Care and Support Services		
	Other:		
	Service Utilization Data		
	Numbers of unduplicated clients, numbers of units of service provided		
	Demographic information regarding who is and is not accessing care		
	Service Cost Data		
	Unit Cost for each service, known or estimated		
	Cost-effectiveness data, if available		
	Other:		
	Qualitative and Needs Assessment Data		
	Focus Groups		
	Client Surveys		

Check if used	Data/Information Used for Priority Setting and Allocation of Funds	Current as of *(Mo/Yr)*	Used by *(e.g. full Planning Council, Priorities/ Allocation Committees)*
	Key Informant Interviewees		
	Estimates of service gaps in the EMA's Title I continuum of HIV/AIDS care		
	Estimates of unmet need among clients not in primary care		
	Other Relevant Data		
	Co-morbidity, poverty, insurance status data from Table 6		
	Information on other available services in the community, including services provided by other CARE Act Titles		
	Information on other funding streams, including those listed in Table 9		

TABLE 9: TITLE I FUNDING IN THE CONTEXT OF OTHER HIV SERVICE FUNDING

INSTRUCTIONS

Table 9 is to be used by the applicant to report on the availability of public funding for HIV-related care services within the EMA from Federal, State and local sources for the fiscal year that most closely corresponds to the Title I FY 2004 budget period.

A. Applicants are requested to report on the first five patient related service categories listed below.

Home and Community-Based Support Services – This service category includes funds available to serve persons/families with HIV/AIDS, by funding source, to provide:

- Child welfare services;
- Buddy/companion programs;
- Case management;
- Client advocacy;
- Psychosocial support services;
- Day/respite care (for children or adults);
- Outreach services;
- Health education/risk reduction;
- Food services (home-delivered meals, food banks, nutritional supplements);
- Housing assistance/housing-related services;
- Transportation;
- Emergency financial assistance; and
- Other support services.

Ambulatory/Outpatient Medical Care – This service category includes funds available to provide ambulatory outpatient medical care and medications to persons/families with HIV/AIDS. These services are defined in Appendix 3 of this Guidance:

State AIDS Drug Assistance Program (ADAP) – This service category includes funds available to support the State ADAP. In the first column include the amount of funds the Planning Council allocated from the EMA's Ryan White Title I CARE Act funding to support the State ADAP. For the other funding sources on the table, include only the amount of funding supporting people with HIV/AIDS within the geographic area of the EMA, not for the entire State(s).

Other Outpatient/Community-Based Primary Medical Care Services – This service category includes funds available to serve persons/families with HIV/AIDS to provide:

- oral health;
- home primary medical care;

- mental health services;
- rehabilitation services;
- substance abuse services; and
- other outpatient/community-based healthcare services not included in the service categories listed above.

Inpatient Medical Care Services – This service category includes funds available to serve persons/families with HIV/AIDS to provide:

- Inpatient personnel costs that prevent unnecessary hospitalizations and/or that expedite discharge as medically appropriate, as specified under Title I of the CARE Act
- Other inpatient medical care services (not fundable with Ryan White funds)

B. The rest of the categories are grantee or Planning Council related and should be reported accordingly.

Grantee Administrative Costs, Planning Council Support, and Program Support – Do not list direct service providers' administrative costs here; rather, include them in the allocation to specific services. The row headings in column 1 of Table 9 identify the categories of funding available to the EMA, which are to be reported as: (1) an aggregate amount for each service category; and (2) as a proportion of the amount of Ryan White Title I, Federal, State, and local funding available for a service category. Except where specifically noted, applicants should use the best available fiscal data for a 12-month period corresponding to the FY 2003Title I fiscal year.

Ryan White Title I Funds – In column 1, enter the amount of FY 2003 formula and supplemental funds allocated to each broad service category, together with any prior year(s) funds which were carried over or available for expenditure in FY 2003. In column 2, indicate the proportion that the aggregate amounts represent out of the total amount of funds available for each service category from all Ryan White Title I, Federal, State, and local funding sources.

Other Federal Funds – Include in column 3, the total amount of FY 2003 funds available for each broad service category from the following Federal sources: Ryan White Titles II, III, IV, and SPNS; HRSA-funded pediatric/family demonstration projects; HOPWA; locally-allocated Community Development Block Grant funding (CDBG); National Institutes of Health (NIH) AIDS Clinical Trials Group (ACTG) and Community Projects for Clinical Research in AIDS (CPCRA); Substance Abuse and Mental Health Services Administration (SAMHSA) HIV funds; and other identifiable Federal funding. In column 4, indicate the proportion that the aggregate amounts represents out of the total amount of funds available for each service category from all Ryan White Title I, Federal, State, local, and other funding sources.

State Funds – Include in column 5 the aggregate amount of State-appropriated funds allocated to each of the four broad service categories listed in the Table. In column 6, indicate what proportion the aggregate amounts represent out of the total amount of funds available for each service category from all Ryan White Title I, Federal, State, local, and other funding sources.

Local Funds – Include in column 7 the total amount of local city and/or county general revenue spent on services to persons with HIV/AIDS, for each broad service category. To the extent possible, data reported should reflect all funding to support persons with HIV/AIDS (e.g., local general assistance or TANF payments to this population). In column 8, indicate what proportion the aggregate amounts represent out of the total amount of funds available for each service category from all Ryan White Title I, Federal, State, local, and other funding sources. Include totals for the funds both horizontally and vertically.

TABLE 9: TITLE I FUNDING IN THE CONTEXT OF OTHER PUBLIC FUNDING

EMA:										
Services	**Amount and Percent of Public Funding by Source**									
	Ryan White Title I		Other Federal Funds		State Funds		Local Funds		**TOTAL FUNDS**	
	Funds	%	Funds	%	Funds	%	Funds	%	Funds	%
Home/Community-Based Support Services										
Ambulatory/Outpatient Medical Care										
State AIDS Drug Assistance Program										
Other Outpatient/Community-based Primary Medical Care Services										
Inpatient Medical Care Services										
Grantee Administrative Costs, Program Support, and Planning Council Support										
TOTAL FUNDS										

TABLE 10: FY 2004 IMPLEMENTATION PLAN

INSTRUCTIONS

For each of the FY 2004 priorities listed in Table 10, the applicant must provide one or more service goals with measurable program objectives. The service goals and objectives comprise the FY2004 Implementation Plan and each objective must include:

- service/activity to be provided;
- target population;
- service unit and definition;
- number of clients to be served;
- number of service units to be delivered
- time frame; and
- an estimated amount of funds required to meet the objective.

Where multiple objectives exist beneath one service goal, the estimated amount of funding must be broken out by objective. ***Service goals or objectives funded under MAI must be clearly identified.***

Examples of goals and objectives developed for Title I service priorities are provided in the sample Implementation Plan on page 85.

PAGE_____OF_____

TABLE 10: FY 2004 IMPLEMENTATION PLAN

EMA: _____

Prepared by: _____

Service Priority Name:					
Service Priority Number:		**Ref Comprehensive Plan Goal:**			
Service Goal:					
Objective/s: *List quantifiable and time-limited objectives relating to the Service Priority named above. Where appropriate, list multiple objectives that are required to implement a new service, or to continue an existing service. For example, a new case management program may require multiple objectives such as: 1) hire two case managers; 2) train case managers in EMA protocols; 3) begin case management services; and 4) evaluate case-management services; etc.*	**Service Unit Definition:** *Provide the name and definition of the unit of service to be provided (e.g. a one-hour face-to-face encounter, one round-trip bus ride).*	**Quantity:** *Provide the number of people to be served and service units to be provided during the grant year.*		**Time Frame:** *Indicate the estimated duration of activity relating to the objective listed.*	**FY 2004 Funds:** *Provide the approximate amount of Title I funds to be used to provide this service. Where possible, divide funding among individual objectives.*
		Number of People to be Served	Total number of Service Units to be Provided		
1.					$
2.					$
3.					$
Service Priority Number:		**Service Priority Name:**			
Service Goal:		**Ref Comprehensive Plan Goal:**			
Objective/s:	**Service Unit Definition**	**Quantity:**		**Time Frame:**	**FY 2004 Funds**
		Number of People to be Served	Total number of Service Units to be Provided		
1.					$
2.					$
3.					$

SAMPLE SAMPLE SAMPLE SAMPLE

TABLE 10: FY 2004 IMPLEMENTATION PLAN

EMA: ANYWHERE, USA

Service Priority Name: Primary Medical Care				**Page 1 of 13**	
Service Priority Number: 1				**Prepared by: Mary Jones**	
Service Goal: (1A). To ensure accessible HIV/AIDS primary medical care that is consistent with the US Public Health Service Treatment Guidelines for all eligible PLWH in the EMA.					
Objective/s:	**Service Unit Definition:**	**Quantity:**		**Time Frame:**	**FY 2004 Funds:**
		Number of People to be Served	Total # of Service Units to be Provided		
1. **Objective 1**.Continue HIV/AIDS primary medical care through 4 community clinics located in each quadrant of the EMA	45 minutes office visit	320	2,109	03/01/04 to 02/28/05	$560,951
2. Begin HIV/AIDS medical care in the rural southwest corner of the EMA	45 minutes office visit	50	148	03/01/04 to 02/28/05	$45,715
Service Priority Number: 1		**Service Priority Name: Primary Medical Care**			
Service Goal: (1B). To improve health outcomes for HIV+ African American women and their children					
Objective/s:	**Service Unit Definition**	**Quantity:**		**Time Frame:**	**FY 2004 Funds**
		Number of People to be Served	Total # of Service Units to be Provided		
1. Increase from 1 to 4 the number of days the HIV/AIDS specialty clinic --targeting African American women and their children--is open	45 minutes office visit	114 women & 52 Children	400	06/01/04 to 02/28/05	$170,000 of MAI Funding
2. Provide HIV/AIDS expert treatment consultation services at an HIV/AIDS clinic targeting African American women and their children	3O minutes consultation	80	240	03/01/04 to 02/28/05	$12,000 of MAI Funding

Service Priority Name: Case Management				**Page 2 of 13**	
Service Priority Number: 2				**Prepared by: Mary Jones**	
Service Goal: (2A). To increase access to HIV/AIDS primary medical care and support services for multiply diagnosed PLWH in the EMA					
Objective/s:	**Service Unit Definition:**	**Quantity:**		**Time Frame:**	**FY 2004 Funds:**
		Number of People to be Served	Total number of Service Units to be Provided		
1. Establish case-manager-led multi-disciplinary treatment teams to provide quarterly case conferences for all multiply diagnosed PLWH in the EMA.	1 hour case conference	100	400	05/01/04 to 02/28/05	$26,000

TABLE 11: SUMMARY OF PRIORITY SERVICES FUNDED IN FY 2003 AND TO BE FUNDED IN FY 2004

INSTRUCTIONS

Use the shaded columns titled "Numerical order of priorities" to numerically order priorities by fiscal years. Please note that priorities should be reported for FY2003 and FY 2004. The first service listed should be ranked as the highest in priority for both fiscal years. If a community has "sub-priorities" (see next paragraph), a logical and self-evident ordering system (e.g., 1.1, 1.2, 1.3, or 1.a., 1.b., 1.c., etc.) should be followed for listing them. Additional pages may be added as required. List "Capacity Development" as a sub-priority under each appropriate service category.

List under the columns titled "Service Priority" (using the Glossary in Appendix 3 of the Guidance) those service categories determined by the Planning Council for the current fiscal year (FY) and those determined for the upcoming FY 2004 Title I funding.

In the column titled "Allocation Amount", enter total FY 2003and 2004 funds allocated for each category. In the next column, enter the percent of the total funds that the allocation represents. At the bottom of each column, show the total for each.

TABLE 11: SUMMARY OF PRIORITY SERVICES FUNDED IN FY 2003 AND TO BE FUNDED IN FY 2004

EMA:						**Page _____ of _____**	
Numerical order of priorities 2003	Service Priority FY **2003**	Allocation Amount	%	Numerical order of priorities 2004	Service Priority FY **2004**	Allocation Amount	%
		$				**$**	
		$				**$**	
		$				**$**	
		$				**$**	
		$				**$**	
		$				**$**	
		$				**$**	
		$				**$**	
		$				**$**	
		$				**$**	
		$				**$**	
		$				**$**	
TOTALS FY 2003		**$**		**TOTALS FY 2004**		**$**	

Please use additional pages as needed and number them consecutively.

SECTION VI:

APPENDICES

Appendix 1:

FY 2004 Agreements and Compliance Assurances

The Chief Elected Official (CEO) of the Eligible Metropolitan Area (EMA), or her/his designee, must include a signed copy of the attached form with the Title I grant application. This form lists the program assurances, which must be satisfied in order to qualify for a Title I Grant as required under the CARE Act.

RYAN WHITE COMPREHENSIVE AIDS RESOURCES EMERGENCY ACT AMENDMENTS OF 1996 TITLE I HIV EMERGENCY RELIEF GRANT PROGRAM FY 2004 Agreements and Compliance Assurances

I, the Chief Elected Official of the Eligible Metropolitan Area (hereinafter referred to as the

EMA) - _____,
designated pursuant to the provision of Title I of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 as amended, hereby certify that:

A. as required in Section 2604 (a)(1) and (2):

1. the allocation of funds and services within the EMA will be made in accordance with the priorities established, pursuant to **Section 2602 (b)(4)(A)**, by the HIV Health Services Planning Council that serves the EMA; and
2. funds provided under **Section 2601** will be expended only for the purposes described in **Sections 2604 (b) and (c)**

B. as required in **Section 2605 (a):**

1. funds received under this Title will be used to supplement, not supplant, State funds made available in the year for which the grant is awarded to provide HIV-related services to individuals with HIV disease;
2. During the grant period, political subdivisions within the EMA will maintain at least their prior fiscal year's level of expenditures for HIV-related services for individuals with HIV disease ;
3. political subdivisions within the EMA will not use funds received under this Title in maintaining the level of expenditures for HIV-related services as required in the above paragraph (2); and,
4. documentation of this Maintenance of Effort is required.

C. the EMA:

1. pursuant to Section 2602(b) has an HIV Health Services Planning Council that:

a. is reflective of the demographics of the epidemic, with particular consideration given to disproportionately affected and historically underserved groups and subpopulations, and is inclusive of representatives from all categories cited in the legislation;

b. is not chaired solely by an employee of the grantee **(Section 2602(b)(3)(c));**

c. maintains an open process for member nominations , with candidates selected based on locally delineated and publicized criteria, including a conflict-of-interest standard **(Section 2602(b)(1);**

d. is not directly involved in the administration of grants and does not designate (or is not otherwise involved in the selection of) particular entities as recipients of this grant, in accordance with HRSA/HAB guidance on Planning Council Roles and Responsibilities, and that individuals on the Council will not participate in the process of selecting entities to receive funds if that person has a financial interest in the entity, is an employee of that entity, or is a member of such entity (Sections 2602(b)(5)(A)

e. has procedures for addressing grievances with respect to priority setting and allocation of resources, including procedures for submitting grievances that cannot be resolved to binding arbitration, and are consistent with models developed by HRSA **(Section 2602(b)(6)**;

f. has documented the duties of the Council consistent with Section 2602(b)(4) of the legislation;

g. has incorporated or referenced all of the above provisions in the Planning Council by-laws or operating procedures;

h. has ensured that meetings of the Planning Council are open to all members of the general public, and that there is a system to ensure public announcement of all meetings;

i. has ensured that Planning Council minutes must be certified by the Planning Council Chair and made available to the public no later than two weeks after they have been approved by the Planning Council or the Executive Committee. (The entire process should take no more than six weeks);

j. has ensured that the Planning Council has a location, accessible by the public, where minutes and related information can be inspected and copied if requested;

k. has taken steps to guard against disclosure of personal information that would constitute an invasion of privacy, including medical or other personnel matters that should not be discussed;

l. has taken steps to ensure that when Planning Council committees or subgroups make recommendations or take actions subject to Planning Council review or ratification, records of the proposed recommendations and actions should be made available for public inspection;

m. has noted that in situations where the State, County or local statute, ordinance or regulation is more stringent than the legislative language cited above, those statutes or ordinances take precedence — otherwise, the new provisions contained in the Reauthorized CARE Act take precedence;

n. has noted that as a condition of award, grantees will be required to provide evidence that the Planning Council is in compliance within 60-days of their FY 2004 Title I Notice-of-Grant-Award (i.e., by May 1, 2004); and

o. has ensured that CARE Act funded entities within the EMA maintain appropriate relationships with entities considered key points of access to the healthcare system for the purpose of facilitating early-intervention services for individuals diagnosed as being HIV positive **(Section 2605 (a)(3))**;

2. has entered into intergovernmental agreements pursuant to Section 2602(a), with the CEOs of the political subdivisions in the EMA that provide HIV-related health services and for which the number of AIDS cases in the last five years constitutes not less than 10 percent of the cases reported for the EMA; and

3. has developed a comprehensive plan for the organization and delivery of health services to individuals with HIV disease, in accordance with **Section 2602 (b)(4)(B).**

D. As required in Section 2605 (a)(3): entities within the EMA that receive Title I funds shall participate in an established HIV community-based continuum of care, if such continuum exists within the EMA.

E. pursuant to **Section 2605(a)(4)**, Title I funds will not be used to pay for any item or service that can reasonably be expected to be paid:

1. under any State compensation program, insurance policy, or any Federal or State health benefits program or
2. by an entity that provides health services on a prepaid basis.

F. pursuant to Section 2605(a)(5) to the maximum extent practicable, that:

1. HIV primary medical care and support services provided with assistance made available under this Title will be provided without regard to:

   a. the ability of the individual to pay for such services or

   b. the current or past health conditions of the individuals to be served;

2. Such services will be provided in a setting that is accessible to low-income individuals with HIV disease; and

3. A program of outreach services will be provided to low-income individuals with HIV disease to inform them of such services.

G. in the provision of services with assistance provided under Title I, any charges for services will be made in accordance with the provisions specified in Section 2605(e).

H. pursuant to Section 2604(e)(1) and in accordance with the legislative definition of administrative costs (Sections **2604(e)(2) and (3),** will maintain administrative costs of the grantee at no more than 5 percent of the grant; and, of the funds allocated to entities, will not exceed an aggregate amount of 10 percent of such funds for administrative purposes.

I. pursuant to **Sections 2602(b)(6), (c)(1) and (2),** has developed grievance procedures with respect to funding that are determined by HRSA to be consistent with its model procedures, including a process for submitting grievances to binding arbitration.

J. pursuant to **Section 2604(b)(4)(A),** grant funds of not less than the percentage of Women, Infants, Children and Youth with AIDS to the total population of persons with AIDS in the EMA shall be used to provide health and support services to each population with HIV disease, including treatment measures to prevent the perinatal transmission of HIV.

K. pursuant to **Section 2605(a)(6),** agrees to participate in the Statewide Coordinated Statement of Need process initiated by the State, and ensure that the services provided under the EMA's comprehensive plan are consistent with the SCSN.

L. pursuant to the Minority AIDS Initiative, agrees that MAI funds will be expended in a manner consistent with legislative intent.

M. pursuant to **Section 2602(e)**, assures that Planning Council member training, based on the plan submitted in the application will take place.

N. pursuant to Section **2604(c)(1)**, assures that Quality Management Programs that meet HRSA requirements are in place.

SIGNED:_____ **Title:**_____

Chief Elected Official

Eligible Metropolitan Area:_____

Date:_____

Appendix 2

Estimated Number of Women, Infants, Children, and Youth Living with AIDS as a Percentage of All Persons Living with AIDS in Eligible Metropolitan Areas
Data Period: 7/1/1991 through 6/30/2002

DATA WILL BE MAILED TO GRANTEES

Appendix 3:

Glossary of HIV-Related Service Categories

NOTE: The following list of HIV-related service categories are defined by the HIV/AIDS Bureau. They are also used by Titles II, III and IV. Furthermore, these definitions can be found in the CARE Act Data Reporting system (CADR)

Ambulatory/outpatient medical care is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist or nurse practitioner in an outpatient setting. This includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary Medical Care* for the Treatment of HIV Infection includes the provision of care that is consistent with the Public Health Service's Treatment Guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Mental health services are psychological and psychiatric treatment and counseling services to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

Oral health care includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

Substance abuse services-outpatient are the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) provided in an outpatient setting rendered by a physician or under the supervision of a physician, or by other qualified personnel.

Substance abuse services-residential are the provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) provided in an inpatient health service setting (short-term).

Rehabilitation services include services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training.

Home health care is the provision of services by a homemaker, home health aide, personal caretaker, or attendant caretaker. This definition also includes non-medical, non-nursing assistance with cooking and cleaning activities to help disabled clients remain in their homes.

Home health professional care is the provision of services in the home by licensed health care workers, such as nurses.

Home health: specialized care is the provision of services that include intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other high-tech therapies.

Case management services are a range of client-centered services that links clients with health care, psychosocial and other services. Ensures timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Also includes inpatient case management services that prevent unnecessary hospitalization or that expedite discharge from an inpatient facility. Key activities include: (1) initial assessment of service needs, (2) development of a comprehensive, individualized service plan, (3) coordination of services required to implement the plan and client monitoring to assess the efficacy of the plan, and (4) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. May include client-specific advocacy and/or review of utilization of services.

Buddy/companion service is an activity provided by volunteers/peers to assist the client in performing household or personal tasks and providing mental and social support to combat the negative effects of loneliness and isolation.

Child care services are the provision of care for the children of clients who are HIV-positive while the clients are attending medical or other appointments or attending Title-related meetings, groups, or training. NOTE: This does not include daycare while client is at work.

Child welfare services include family preservation/unification, foster care, parenting education, and other child welfare services. Services designed to prevent the break-up of a family and to reunite family members. Foster care assistance to place children under the age of 21 years, whose parents are unable to care for them, in temporary or permanent homes and to sponsor programs for foster families. Other services related to juvenile court proceedings, liaison to child protective services, involvement with child abuse and neglect investigations and proceedings, or actions to terminate parents' rights. Presentation or distribution of information to biological, foster, and adoptive parents, future parents, and/or caretakers of HIV-positive children about risks and complications, care-giving needs, and developmental and emotional needs of children.

Client advocacy is the provision of advice and assistance obtaining medical, social, community, legal, financial, and other needed services. Advocacy does not involve coordination and follow-up on medical treatments, as case management does.

Day or respite is the provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client.

Developmental assessment/early intervention services are the provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. Involves assessment of an infant's or child's developmental status and needs in relation to the involvement with the education system, including assessment of educational early intervention services. Includes comprehensive assessment of infants and children taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational settings for HIV-affected clients, and education/assistance to schools.

Early intervention services for Titles I and II are a combination of services that include outreach, HIV counseling, testing, referral and provision of outpatient medical care and supportive services designed and coordinated to bring individuals with HIV disease into the local HIV continuum of care.

Emergency financial assistance is the provision of short-term payment for essential utilities and for medication assistance when other resources are not available.

Food bank/home-delivered meals involves the provision of actual food, meals, or nutritional supplements. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item.

Health education/risk reduction is the provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information, including information dissemination about medical and psychosocial support services and counseling, to help clients with HIV improve their health status.

Housing assistance is limited to short-term or emergency financial assistance to support temporary and/or transitional housing to enable the individual or family to gain and/or maintain medical care. Use of CARE Act funds for short-term or emergency housing must be linked to medical and/or healthcare or be certified as essential to a client's ability to gain or maintain access to HIV-related medical care or treatment.

Housing related services include assessment, search, placement, and advocacy services provided by professionals who possess an extensive knowledge of local, State and Federal housing programs and how they can be accessed.

Legal services the provision of services to individuals with respect to powers of attorney, do not resuscitate orders, wills, trusts, bankruptcy proceedings, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it

relates to services eligible for funding under the CARE Act. It does not include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.

Nutritional counseling is the provision of nutrition education and/or counseling by a licensed registered dietitian outside of a primary care visit. Nutritional counseling provided by other than a licensed/registered dietitian should be recorded under "Psychosocial support services."

Outreach services: include programs which have as their principal purpose identification of people with HIV disease so that they may become aware of, and may be enrolled in, care and treatment services (i.e., case finding), not HIV counseling and testing nor HIV prevention education. Outreach programs must be planned and delivered in coordination with state and local HIV-prevention outreach programs to avoid duplication of effort, be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection, be conducted at times and in places where there is a high probability that HIV-infected individuals will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

Permanency planning is the provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.

Psychosocial support services are the provision of support and counseling activities, including alternative services (e.g., visualization, massage, art, music, and play), child abuse and neglect counseling, HIV support groups, pastoral care, recreational outings, caregiver support, and bereavement counseling. Includes other services not included in mental health, substance abuse or nutritional counseling that are provided to clients, family and household members, and/or other caregivers and focused on HIV-related problems.

Referral for health care/supportive services is the act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made formally from one clinical provider to another, within the case management system by professional case managers, informally through support staff, or as part of an outreach program.

Referral to clinical research is the provision of education about and linkages to clinical research services through academic research institutions or other research service providers. Clinical research involves studies in which new treatments—drugs, diagnostics, procedures, vaccines, and other therapies—are tested in people to see if they are safe and effective. All institutions that conduct or support biomedical research involving people must, by Federal regulation, have an IRB that initially approves and periodically reviews the research.

Hospice Services are provided through **Home Based Hospice Care**, including nursing care, counseling, physician services, and palliative therapeutics provided by a hospice program to patients in the terminal stages of illness in their home setting. And services provided through **Residential Hospice Care**, including room, board, nursing care, counseling, physician services,

palliative therapeutics provided to patients in the terminal stages of illness in a residential setting, including non-acute care section of a hospital that has been designated and staffed to provide hospice services for terminal patients.

Transportation services include conveyance services provided, directly or through voucher, to a client so that he or she may access health care or support services.

Treatment adherence services provide counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments.

Drug Reimbursement Program is an ongoing service/program to pay for approved pharmaceuticals and/or medications for persons with no other payment source. See State-ADAP and Local/Consortium Drug Reimbursement Program.

State-Administered AIDS Drug Assistance Program (ADAP), authorized under Title II of the CARE Act, provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid.

Local/Consortium Drug Reimbursement Program is established, operated, and funded locally by a Title I EMA or a consortium to expand the number of covered medications available to low-income patients and/or broaden eligibility beyond that established by a State-operated Title II or other State-funded Drug Reimbursement Program. *Medications* include prescription drugs provided through ADAP to prolong life or prevent the deterioration of health. This definition does not include medications that are dispensed or administered during the course of a regular medical visit or that are considered part of the service visit. If medications are paid for and dispensed as part of an *Emergency Financial Assistance Pro*gram, they should be reported as such.

Health Insurance is a program of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

Appendix 4:

HIV/AIDS Epidemiology Data For The EMA

The following information is provided to assist applicants in responding to the FY 2004 Title I Guidance. The following table(s) is/are enclosed for your use:

- AIDS Incidence: estimates of cases diagnosed from January 2001 through December 2002, by age, race/ethnicity, mode of exposure category, and sex.

- AIDS Prevalence: estimates of the number of persons living with AIDS at the end of December 31, 2002 by age, race/ethnicity, mode of exposure category, and sex. (Calculated as adjusted AIDS incidence minus adjusted deaths of persons with AIDS).

- Prevalence of Diagnosed HIV (not AIDS): estimates of the number of persons living with HIV (not AIDS) at the end of December 31, 2002 by age, race/ethnicity, mode of exposure category and sex for EMAs within 29 states and the Virgin Islands.

EMAs may use local data and estimates if they feel they are more accurate. EMAs choosing to use local data or estimates must provide an explanation of why this data was used and provide the source of the data in the narrative in the Severe Need section.

HIV Prevalence Data

HIV and AIDS data reported to CDC through December 31, 2002 were statistically adjusted for delays in reporting and for unreported risk. These estimates are based on national adjustments and therefore State health departments may choose to modify them or substitute other data that may be available locally. Note the following important considerations:

- These data are estimates and do not represent actual case counts of persons with HIV/AIDS. The sum total of estimates for each category may not match the EMA totals because of rounding.

- Small numbers should be interpreted with caution. As with any statistically adjusted data, the inherent uncertainty of these estimates is greater for small numbers than for larger ones.

- Adjustments for unreported risk (i.e., risk redistribution) are based on historical patterns of risk ascertainment and reclassification. For both AIDS and HIV data, the redistribution is not based on the individual EMA's reclassification patterns, but rather on the patterns observed in the geographic region.

- Research has shown that the risk redistribution for the extremely low incidence categories no longer produces valid estimates. For this reason, CDC has grouped cases attributed to hemophilia/coagulation disorder and receipt of blood transfusion, blood components, or tissue into estimates of "other" exposure categories for adults/adolescent and pediatric cases.

- Cases reported in 2003 using the new OMB race/ethnicity categories where 2 or more non- Hispanic race categories were indicated are categorized as multi-race in these tables.

- These data tables have been provided by the CDC to State/local surveillance staff. You are encouraged to consult with your local HIV/AIDS surveillance program staff to assure that data are released in accordance with State and local data release policies.

- For AIDS incidence tables, age group represents age at AIDS diagnosis. For HIV and AIDS prevalence tables, age group reflects age as of December 31, 2002.

- Diagnosed HIV (not AIDS) prevalence represents estimates of the number of persons with HIV who had not progressed to AIDS and who were living at the end of December 31, 2002. These estimates do not represent all persons living with HIV infection (i.e., estimates do not include persons living with HIV who have not been tested or who have been tested in an anonymous setting only).

HIV prevalence data are only provided for EMAs within 29 states and the Virgin Islands that have had name-based HIV reporting systems in place prior to 1999. These states include:

- Alabama
- Arkansas
- Arizona
- Colorado
- Florida
- Idaho
- Indiana
- Iowa
- Louisiana
- Michigan
- Minnesota
- Mississippi
- Missouri
- Nebraska
- Nevada
- New Mexico
- North Carolina
- North Dakota
- Ohio
- Oklahoma
- South Carolina
- South Dakota
- Tennessee
- Utah
- Virginia
- Virgin Islands
- West Virginia
- Wisconsin
- Wyoming

- New Jersey

CDC will not provide HRSA/HAB with modeled estimates of diagnosed HIV (not AIDS) prevalence for areas that have implemented HIV reporting since 1999 or that have not yet implemented HIV reporting. These areas may use locally available HIV data or adjust the estimate provided by CDC in September 2001 using an adjustment factor based on the change in AIDS prevalence from June 2000 to December 2002.

For example, the adjustment factor can be calculated by dividing AIDS prevalence as of June 2001 (provided with this guidance) by AIDS prevalence as of June 2000 (provided in July 2001). This adjustment factor can then be multiplied by the diagnosed HIV (not AIDS) prevalence estimate at the end of June 2000 to obtain an estimate of diagnosed HIV prevalence at the end of June 2001. A specific example is provided below:

Diagnosed HIV (not AIDS) prevalence as of June 2000 = 900 (information provided Sept. 2001)
AIDS prevalence as of June 2000 = 1000 (Information provided July 2001)
AIDS prevalence as of December 2003 = 1200 (Information provided with this guidance)

$$\text{Adjustment factor} = \frac{1200}{1000} = 1.2$$

Diagnosed HIV (not AIDS) prevalence as of December 2002 = 900 x 1.2 = 1080

Appendix 5:

Instructions for Completing Standard Form (SF) 424 and Related Documents Including Budget Narrative and Justification

The Public Health Service (PHS) Application Kit, PHS Form 5161-1, is available on the internet, http://forms.psc.gov/forms/PHS/ . The following information supplements the instructions for completing the SF 424 and related forms.

Beginning October 1, 2003, applicants are required to have a Dun and Bradstreet DUNS number to apply for a grant or cooperative agreement from the Federal government. The DUNS number is a nine-digit identification number, which uniquely identifies business entities. Obtaining a DUNS number is easy and there is no charge. Instructions for obtaining a DUNS number is included with the application guidance cover letter.

SF- 424Form

The DUNS Number must appear in the top margin of the SF 424

Item 6 of the face page and part C on page 5 of PHS 5161: EMAs must provide the 12-digit Employer Identification Number (EIN) assigned by PHS and used by the grantee for requesting payment from the Payment Management System. The 12-digit number can be found on the most recent Notice of Grant Award.

Item 10: The OMB Catalog of Federal Domestic Assistance Number for the CARE Act Grant program is 93.914.

Item 13: All EMAs should submit a 12-month budget covering the period March 1, 2004 through February 28, 2005. Contracts may not extend beyond the budget period (2/28/2005).

Item 14a: Identify the specific Congressional District in which the applicant's organization is located. Only one Congressional District may be included in 14a.

Item 14b: Identify all Congressional Districts affected by the program or project.

Item 15: On line 15a, enter the amount of financial support requested from HRSA under the Title I grant program for a 12-month budget period. Grantees will receive information on the availability of funds for FY 2004 shortly after the President has signed a Congressional appropriation for the CARE Act. Until such time as an appropriation is signed, the amount of funds requested should be based on the annualized amount of the FY 2001 formula funding level and supplemental funding needed to support activities described in this application.

Item 16: Executive Order (EO) 12372 establishes a system for State and local government review of proposed Federal assistance applications. Applicants should contact their State Single Point of Contact (SPOC) as early as possible to alert him/her to the prospective application and to receive any necessary instructions on the State process. For proposed projects serving more

than one State, the applicant is advised to contact the SPOC of each affected State. A current list of SPOCs for participating States is included in the application kit. This information also is available on the HHS website <http://www.hhs.gov/grantsnet/>.

SPOCs should send State process recommendations to the attention of the Grants Management Officer in HRSA/HAB. The SPOC has 60 days after the application deadline date to submit recommendations to HRSA/HAB for competing renewal applications (all EMAs). HRSA/HAB will take all recommendations made during the time period under advisement, but cannot be bound by any recommendations received after that date.

Enter the signature of the authorized representative of the applicant EMA. All requests for Federal assistance require this signature. In the case of Title I Applicants, the authorized representative is the Chief Elected Official (CEO) of the applicant EMA. A letter updating the name and title of the authorized representative must accompany the FY 2004 Title I Grant Application. If the CEO designates authority to sign Title I applications, the letter must state the name(s) and/or position(s) of the designee and all others who have been granted additional signature authority.

SF-424 A, Budget Information -- Non-construction Programs

Sections A and B of Form SF-424-A should be completed for a one-year period. Do not complete Sections C, D or E. Section B is a breakdown of the budget by specific categories. Line item 6(f) requests a total budget of all contract arrangements. Allowable costs and how those costs may be allocated by States and local governments receiving PHS grants is set forth in 45 CFR Part 92. The cost principles prescribed for grant recipients are contained in the Office of Management and Budget (OMB) Circular A-87 for State and local governments. These documents are available on the HHS website <http://www.hhs.gov/grantsnet/>.

Checklist from PHS 5161-1 Grant Application Kit, Page 25, Part C

Indicate the Administrative Official responsible for the Title I grant. The Administrative Official refers to the official responsible for the fiscal integrity of the grant (usually the Chief Financial Officer). Program/Project Director refers to the official responsible for the day-to-day administration of the program. The Administrative Official and the Program/Project Director should not be the same person. Do not include the name of the CEO in this section.

Budget Narrative/Justification

Applications for grant funds must provide a categorical budget and a budget narrative/justification. General guidance on costs by budget category is provided below. For more information on allowable administrative, quality management, Planning Council, and program support costs, refer to the HAB/DSS "Issue Paper on Administrative Costs" (January 31, 1997), the Quality Management letter, and consult the Title I Manual.

Grantee Administrative Costs

A budget narrative must be included and provide a line-item breakout of the budget, detailing the amount of funds budgeted for each item. Administrative costs are funds to be used by the grantee for routine grant administration and monitoring activities. These activities include the development of this application under Title I, the receipt and disbursal of program funds, the development and establishment of reimbursement and accounting systems, the preparation of routine programmatic and financial reports, and compliance with grant conditions and audit requirements. Administrative costs also may include all activities associated with the grantee's contract award procedures, including the development of requests for proposals, contract proposal review activities, negotiation and award of contracts, as well as the development and implementation of grievance procedures. In addition, administrative funds may be used for post-award activities such as monitoring of contracts, written documentation of on-site visits, reporting on contracts, and funding reallocation activities. Finally, administrative costs should address expenses related to participation in the Statewide Coordinated Statement of Need. These costs cannot exceed 5 percent of the grantee's award (See: Section 2604 (e)(2)).

Travel

Applicants are instructed to limit the use of CARE Act funds for travel to the following circumstances.

1. Applicants should include travel funds in their administrative budgets for travel from the EMA to Washington, DC for required technical-assistance meetings such as the National Grantee Meeting. A minimum of two round trips should be budgeted for grantee staff.

2. Applicants should include three additional round trips for relevant Planning Council members to attend required HAB/DSS technical assistance meetings. This travel expense may be included in either the administrative or Planning Council support budget. If such meetings are not held, the grantee is encouraged to re-budget these funds as necessary.

3. Applicants should limit all other travel to that which is related to the administration of the grant and justified in the budget narrative.

4. Applicants should budget for travel-related expenses to support PLWH participation in required HAB/DSS technical assistance meetings with Title I or other funds. Applicants also should be sure to budget for the support of PLWH during the National Grantee Meeting.

5. All travel for contractors must be local and directly related to the services provided under the specific contract.

6. Budgeting for international travel is not allowed.

Planning Council Support

Funds to be used to support the operation of the Planning Council must be identified as a priority by the Planning Council and may **not** be included in the grantee's administrative cost budget. Planning Council support includes the reasonable and necessary activities listed below.

1. Funds may be used for staff support (i.e. clerical and professional expenses required by the Planning Council for the performance of required Planning Council activities, including routine Planning Council administrative activities).

2. Funds may be used for costs incurred by Planning Council members as a result of their participation on the Planning Council and in the conduct of their required Planning Council activities, in accordance with Chapter 7, Allowable and Unallowable Costs of the *Public Health Service (PHS) Grants Policy Statement*. The *Statement* describes such items as reimbursement of reasonable and actual out-of-pocket costs incurred solely as a result of attending a scheduled meeting, including transportation, meals, baby-sitting fees, and lost wages. Allowable costs are further described in the letter on reimbursable costs for members of consumer/provider boards from the HAB Associate Administrator dated January 5, 2000 which was sent to all grantees and can be found on the HAB website.

3. Funds may be used for costs associated with out-of-town travel for Planning Council members to and from HRSA/HAB required technical assistance meetings; **however, no international travel is allowed.**

4. Funds may be used for costs associated with conducting a needs assessment and other methods for obtaining input on community needs and priorities, such as public meetings, focus groups and ad-hoc panels for the purpose of assisting the Planning Council in setting service priorities in accordance with Sections 2602(b)(4)(A) and (E).

5. Funds may be used for costs associated with the development and update of the comprehensive plan for the organization and delivery of HIV-related services in accordance with Section 2602(b)(4)(B).

6. Funds may be used for costs associated with assessing the efficiency of the administrative mechanism in rapidly allocating funds within the EMA in accordance with Section 2602(b)(4)(C).

7. Funds may be used for costs associated with participation in the development of the Statewide Coordinated Statement of Need in accordance with Section 2602(b)(4)(D). Enter the Signature of the authorized representative of the applicant EMA on the request.

8. Funds may be used for activities associated with publicizing the Planning Council's activities and with publicizing services for HIV-affected/infected populations and sub-populations, and for efforts to substantively enhance community participation in Planning Council activities.

9. Funds may be used for the administration of Planning Council grievance procedures for decisions related to funding as required by the CARE Act in accordance with Section 2602(b)(6).

10. Costs associated with local travel must be specifically related to legislative mandates of the Planning Council and must be budgeted under Planning Council Support. Therefore, all travel costs must be fully justified in the budget narrative.

11. Costs for each Planning Council support activity should be listed separately with a budget justification for each activity.

Program Support

Funds may be used to support program activities that are not service-oriented or administrative in nature, but which contribute to or help improve service delivery. Such activities may include capacity development, technical assistance, program evaluation (including outcome assessment), quality assurance, and assessment of service-delivery patterns. These activities must be established as priorities by the Planning Council and linked to the findings of a comprehensive needs assessment. Activities must meet all other criteria of priority setting in accordance with Sections 2602(b)(4)(A) and (E). Costs for each program-support activity should be listed separately with a narrative justification for each activity. Travel outside of the EMA may not be funded under program support.

Quality Management

Funds may be used to support quality management programs that assist direct-service medical providers in assuring that funded services adhere to established HIV clinical practice standards and PHS Guidelines. In addition, quality management programs must ensure that strategies for improvements to quality medical care include health-related supportive services and that available demographic, clinical and health-care utilization information is used to monitor HIV-related illnesses and trends in the local epidemic. In FY 2003 grantees are allowed to allocate up to 5 percent of the total grant award or $3,000,000 (whichever is less) for quality management activities.

Service Costs

Service costs are the proposed expenditures for services based upon the priorities established by the Planning Council. Aggregate amounts for each category of services must be included. The budget narrative must be consistent with budget information required on SF 424A and service categories outlined in Appendix 3 of this Guidance.